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By Committee on Health Care

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PART I. FINDINGS, GOALS, AND INTENT

NEW SECTION. **Sec. 101.** FINDINGS. The legislature finds that our health and financial security are jeopardized by our ever increasing demand for medical care and by current medical insurance and medical system practices. Current medical system practices encourage public demand for unneeded, ineffective, and sometimes dangerous medical treatments. These practices often result in unaffordable cost increases that far exceed ordinary inflation for essential care. Current total medical and health care expenditure rates should be sufficient to provide access to essential health and medical care interventions to all within a reformed, efficient system.

The legislature finds that too many of our state's residents are without medical insurance, that each year many individuals and families are forced into poverty because of serious illness, and that many must leave gainful employment to be eligible for publicly funded medical services. Additionally, thousands of citizens are at risk of losing adequate medical insurance, have had insurance canceled recently, or cannot afford to renew existing coverage.

The legislature finds that businesses find it difficult to pay for medical insurance and remain competitive in a global economy, and that individuals, the poor, and small businesses bear an inequitable medical insurance burden.

The legislature finds that persons of color have significantly higher rates of mortality, poor health outcomes, and substantially lower numbers and percentages of persons covered by health insurance than general population. It is intended that chapter . . ., Laws of 1993 (this act) make provisions to address the special health care needs of these racial and ethnic populations in order to improve their health status.

The legislature finds that uncontrolled demand and expenditures for medical care are eroding the ability of families, businesses, communities, and governments to invest in other enterprises that promote health, maintain independence, and ensure continued economic welfare. Housing, nutrition, education, and the environment are all diminished as we invest ever increasing shares of wealth in medical treatments.

1 The legislature finds that while immediate steps must be taken, a
2 long-term plan of reform is also needed.

3 <u>NEW SECTION.</u> **Sec. 102.** LEGISLATIVE INTENT AND GOALS. (1) The
4 legislature intends that state government policy stabilize health
5 services costs, assure access to essential services for all residents,
6 actively address the health care needs of persons of color, improve the
7 public's health, and reduce unwarranted health services costs to
8 preserve the viability of nonmedical care businesses.
9 (2) The legislature intends that:
10 (a) Total health services costs be stabilized and kept within rates
11 of increase similar to the rates of general economic inflation within
12 a publicly regulated, private marketplace that preserves personal
13 choice;
14 (b) State residents be enrolled in the certified health plan of
15 their choice that meets state standards regarding affordability,
16 accessibility, cost-effectiveness, and clinically efficacious;
17 (c) State residents be able to choose health services from the full
18 range of health care providers, as defined in section 402(12) of this
19 act, in a manner consistent with good health service management,
20 quality assurance, and cost effectiveness;
21 (d) Individuals and businesses have the option to purchase any
22 health or medical services they may choose in addition to those
23 contained in the uniform benefits package;
24 (e) All state residents, businesses, employees, and government
25 participate in payment for health services, with total costs to
26 individuals on a sliding scale based on income to encourage efficient
27 and appropriate utilization of services and to protect individuals from
28 impoverishment because of health care costs;
29 (f) These goals be accomplished within a reformed system using
30 private service providers and facilities in a way that allows consumers
31 to choose among competing plans operating within budget limits and
32 other regulations that promote the public good; and
33 (g) That a policy of facilitating communication and networking in
34 the delivery, purchase, and provision of health services among the
35 federal, state, local, and tribal governments be encouraged and
36 accomplished by chapter . . ., Laws of 1993 (this act).

(3) Accordingly, the legislature intends that chapter . . ., Laws of 1993 (this act) provide both early implementation measures and a process for overall reform of the health services system.

PART II. EARLY IMPLEMENTATION MEASURES

A. BASIC HEALTH PLAN EXPANSION

NEW SECTION. **Sec. 201.** A new section is added to chapter 70.47 RCW to read as follows:

TRANSFER OF POWER AND DUTIES TO WASHINGTON STATE HEALTH CARE AUTHORITY. The powers, duties, and functions of the Washington basic health plan are hereby transferred to the Washington state health care authority. All references to the administrator of the Washington basic health plan in the Revised Code of Washington shall be construed to mean the administrator of the Washington state health care authority.

NEW SECTION. **Sec. 202.** TRANSFER OF RECORDS, EQUIPMENT, FUNDS. All reports, documents, surveys, books, records, files, papers, or written material in the possession of the Washington basic health plan shall be delivered to the custody of the Washington state health care authority. All cabinets, furniture, office equipment, motor vehicles, and other tangible property used by the Washington basic health plan shall be made available to the Washington state health care authority. All funds, credits, or other assets held by the Washington basic health plan shall be assigned to the Washington state health care authority.

Any appropriations made to the Washington basic health plan shall, on the effective date of this section, be transferred and credited to the Washington state health care authority. At no time may those funds in the basic health plan trust account, any funds appropriated for the subsidy of any enrollees, or any premium payments or other sums made or received on behalf of any enrollees in the basic health plan be commingled with any appropriated funds designated or intended for the purposes of providing health care coverage to any state or other public employees.

Whenever any question arises as to the transfer of any personnel, funds, books, documents, records, papers, files, equipment, or other tangible property used or held in the exercise of the powers and the performance of the duties and functions transferred, the director of

1 financial management shall make a determination as to the proper
2 allocation and certify the same to the state agencies concerned.

3 NEW SECTION. **Sec. 203.** TRANSFER OF EMPLOYEES. All employees of
4 the Washington basic health plan are transferred to the jurisdiction of
5 the Washington state health care authority. All employees classified
6 under chapter 41.06 RCW, the state civil service law, are assigned to
7 the Washington state health care authority to perform their usual
8 duties upon the same terms as formerly, without any loss of rights,
9 subject to any action that may be appropriate thereafter in accordance
10 with the laws and rules governing state civil service.

11 NEW SECTION. **Sec. 204.** RULES AND BUSINESS. All rules and all
12 pending business before the Washington basic health plan shall be
13 continued and acted upon by the Washington state health care authority.
14 All existing contracts and obligations shall remain in full force and
15 shall be performed by the Washington state health care authority.

16 NEW SECTION. **Sec. 205.** VALIDITY OF PRIOR ACTS. The transfer of
17 the powers, duties, functions, and personnel of the Washington basic
18 health plan shall not affect the validity of any act performed prior to
19 the effective date of this section.

20 NEW SECTION. **Sec. 206.** APPORTIONMENT OF BUDGETED FUNDS. If
21 apportionments of budgeted funds are required because of the transfers
22 directed by sections 201 through 205 of this act, the director of
23 financial management shall certify the apportionments to the agencies
24 affected, the state auditor, and the state treasurer. Each of these
25 shall make the appropriate transfer and adjustments in funds and
26 appropriation accounts and equipment records in accordance with the
27 certification.

28 NEW SECTION. **Sec. 207.** COLLECTIVE BARGAINING. Nothing contained
29 in sections 201 through 206 of this act may be construed to alter any
30 existing collective bargaining unit or the provisions of any existing
31 collective bargaining agreement until the agreement has expired or
32 until the bargaining unit has been modified by action of the personnel
33 board as provided by law.

Sec. 208. RCW 70.47.010 and 1987 1st ex.s. c 5 s 3 are each amended to read as follows:

BASIC HEALTH PLAN--FINDINGS. (1) The legislature finds that:

(a) A significant percentage of the population of this state does not have reasonably available insurance or other coverage of the costs of necessary basic health care services;

(b) This lack of basic health care coverage is detrimental to the health of the individuals lacking coverage and to the public welfare, and results in substantial expenditures for emergency and remedial health care, often at the expense of health care providers, health care facilities, and all purchasers of health care, including the state; and

(c) The use of managed health care systems has significant potential to reduce the growth of health care costs incurred by the people of this state generally, and by low-income pregnant women ((~~who are an especially vulnerable population, along with their children~~)), and at-risk children and adolescents who need greater access to managed health care.

(2) The purpose of this chapter is to provide or make more readily available necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost to these persons that does not create barriers to the utilization of necessary health care services. To that end, this chapter establishes a program to be made available to those residents ((~~under sixty-five years of age~~)) not ((~~otherwise~~)) eligible for medicare ((~~with gross family income at or below two hundred percent of the federal poverty guidelines~~)) or medical assistance who share in a portion of the cost or who pay the full cost of receiving basic health care services from a managed health care system.

(3) It is not the intent of this chapter to provide health care services for those persons who are presently covered through private employer-based health plans, nor to replace employer-based health plans. However, the legislature recognizes that cost-effective and affordable health plans may not always be available to small business employers. Further, it is the intent of the legislature to expand, wherever possible, the availability of private health care coverage and to discourage the decline of employer-based coverage.

(4) ((~~The program authorized under this chapter is strictly limited in respect to the total number of individuals who may be allowed to participate and the specific areas within the state where it may be~~

1 ~~established. All such restrictions or limitations shall remain in full~~
2 ~~force and effect until quantifiable evidence based upon the actual~~
3 ~~operation of the program, including detailed cost benefit analysis, has~~
4 ~~been presented to the legislature and the legislature, by specific act~~
5 ~~at that time, may then modify such limitations.~~))
6 <u>(a) It is the purpose of this chapter to acknowledge the initial</u>
7 <u>success of this program that has (i) assisted thousands of families in</u>
8 <u>their search for affordable health care; (ii) demonstrated that low-</u>
9 <u>income, uninsured families are willing to pay for their own health care</u>
10 <u>coverage to the extent of their ability to pay; and (iii) proved that</u>
11 <u>local health care providers are willing to enter into a public-private</u>
12 <u>partnership as a managed care system.</u>
13 <u>(b) As a consequence, the legislature intends to extend an option</u>
14 <u>to enroll to certain citizens above two hundred percent of the federal</u>
15 <u>poverty guidelines within the state who reside in communities where the</u>
16 <u>plan is operational and who collectively or individually wish to</u>
17 <u>exercise the opportunity to purchase health care coverage through the</u>
18 <u>basic health plan if the purchase is done at no cost to the state. It</u>
19 <u>is also the intent of the legislature to allow employers and other</u>
20 <u>financial sponsors to financially assist such individuals to purchase</u>
21 <u>health care through the program. It is also the intent of the</u>
22 <u>legislature to condition access to this plan for nonsubsidized</u>
23 <u>enrollees upon the prior placement of subsidized enrollees, to the</u>
24 <u>extent funding is available.</u>
25 <u>(c) The legislature directs that the basic health plan</u>
26 <u>administrator identify enrollees who are likely to be eligible for</u>
27 <u>medical assistance and assist these individuals in applying for and</u>
28 <u>receiving medical assistance. The administrator and the department of</u>
29 <u>social and health services shall implement a seamless system to</u>
30 <u>coordinate eligibility determinations and benefit coverage for</u>
31 <u>enrollees of the basic health plan and medical assistance recipients.</u>

32 **Sec. 209.** RCW 70.47.020 and 1987 1st ex.s. c 5 s 4 are each
33 amended to read as follows:
34 BASIC HEALTH PLAN--DEFINITIONS. As used in this chapter:
35 (1) "Washington basic health plan" or "plan" means the system of
36 enrollment and payment on a prepaid capitated basis for basic health
37 care services, administered by the plan administrator through
38 participating managed health care systems, created by this chapter.

(2) "Administrator" means the Washington basic health plan administrator, who also holds the position of administrator of the Washington state health care authority.

(3) "Managed health care system" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract basic health care services, as defined by the administrator and rendered by duly licensed providers, on a prepaid capitated basis to a defined patient population enrolled in the plan and in the managed health care system. On and after July 1, 1997, "managed health care system" means a certified health plan, as defined in section 402 of this act.

(4) "Subsidized enrollee" means an individual, or an individual plus the individual's spouse ((~~and/or~~)) or dependent children, ((~~all under the age of sixty-five and~~)) not ((~~otherwise~~)) eligible for medicare or medical assistance, who resides in an area of the state served by a managed health care system participating in the plan, whose gross family income at the time of enrollment does not exceed twice the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services, who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan.

(5) "Nonsubsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children, not eligible for medicare, who resides in an area of the state served by a managed health care system participating in the plan, who chooses to obtain basic health care coverage from a particular managed health care system and who pays or on whose behalf is paid the full costs for participation in the plan, without any subsidy from the plan.

(6) "Subsidy" means the difference between the amount of periodic payment the administrator makes((~~, from funds appropriated from the basic health plan trust account,~~)) to a managed health care system on behalf of ((~~an~~)) a subsidized enrollee plus the administrative cost to the plan of providing the plan to that subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

((~~(6)~~)) (7) "Premium" means a periodic payment, based upon gross family income ((~~and determined under RCW 70.47.060(2),~~)) which an ((~~enrollee~~)) individual, their employer or another financial sponsor

makes to the plan as consideration for enrollment in the plan as a subsidized enrollee or a nonsubsidized enrollee.

((~~(7)~~)) (8) "Rate" means the per capita amount, negotiated by the administrator with and paid to a participating managed health care system, that is based upon the enrollment of subsidized and nonsubsidized enrollees in the plan and in that system.

Sec. 210. RCW 70.47.030 and 1992 c 232 s 907 are each amended to read as follows:

ACCOUNTS. (1) The basic health plan trust account is hereby established in the state treasury. ((~~All~~)) Any nongeneral fund-state funds collected for this program shall be deposited in the basic health plan trust account and may be expended without further appropriation. Moneys in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of enrollees in the plan and payment of costs of administering the plan. ((~~After July 1, 1993, the administrator shall not expend or encumber for an ensuing fiscal period amounts exceeding ninety-five percent of the amount anticipated to be spent for purchased services during the fiscal year.~~))

(2) The basic health plan subscription account is created in the custody of the state treasurer. All receipts from amounts due from or on behalf of nonsubsidized enrollees shall be deposited into the account. Funds in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of nonsubsidized enrollees in the plan and payment of costs of administering the plan. The account is subject to allotment procedures under chapter 43.88 RCW, but no appropriation is required for expenditures.

(3) The administrator shall take every precaution to see that none of the funds in the separate accounts created in this section or that any premiums paid either by subsidized or nonsubsidized enrollees are commingled in any way, except that the administrator may combine funds designated for administration of the plan into a single administrative account.

Sec. 211. RCW 70.47.040 and 1987 1st ex.s. c 5 s 6 are each amended to read as follows:

1 BASIC HEALTH PLAN--PROGRAM WITHIN STATE HEALTH CARE AUTHORITY. (1)
2 The Washington basic health plan is created as ((~~an independent agency~~
3 ~~of the state~~)) a program within the Washington state health care
4 authority. The administrative head and appointing authority of the
5 plan shall be the administrator ((~~who shall be appointed by the~~
6 ~~governor, with the consent of the senate, and shall serve at the~~
7 ~~pleasure of the governor. The salary for this office shall be set by~~
8 ~~the governor pursuant to RCW 43.03.040~~)) of the Washington state health
9 care authority. The administrator shall appoint a medical director.
10 The ((~~administrator,~~)) medical director((~~,~~)) and up to five other
11 employees of the plan shall be exempt from the civil service law,
12 chapter 41.06 RCW.
13 (2) The administrator shall employ such other staff as are
14 necessary to fulfill the responsibilities and duties of the
15 administrator, such staff to be subject to the civil service law,
16 chapter 41.06 RCW. In addition, the administrator may contract with
17 third parties for services necessary to carry out its activities where
18 this will promote economy, avoid duplication of effort, and make best
19 use of available expertise. Any such contractor or consultant shall be
20 prohibited from releasing, publishing, or otherwise using any
21 information made available to it under its contractual responsibility
22 without specific permission of the plan. The administrator may call
23 upon other agencies of the state to provide available information as
24 necessary to assist the administrator in meeting its responsibilities
25 under this chapter, which information shall be supplied as promptly as
26 circumstances permit.
27 (3) The administrator may appoint such technical or advisory
28 committees as he or she deems necessary. The administrator shall
29 appoint a standing technical advisory committee that is representative
30 of health care professionals, health care providers, and those directly
31 involved in the purchase, provision, or delivery of health care
32 services, as well as consumers and those knowledgeable of the ethical
33 issues involved with health care public policy. Individuals appointed
34 to any technical or other advisory committee shall serve without
35 compensation for their services as members, but may be reimbursed for
36 their travel expenses pursuant to RCW 43.03.050 and 43.03.060.
37 (4) The administrator may apply for, receive, and accept grants,
38 gifts, and other payments, including property and service, from any
39 governmental or other public or private entity or person, and may make

arrangements as to the use of these receipts, including the undertaking of special studies and other projects relating to health care costs and access to health care.

(5) ((~~In the design, organization, and administration of the plan under this chapter, the administrator shall consider the report of the Washington health care project commission established under chapter 303, Laws of 1986. Nothing in this chapter requires the administrator to follow any specific recommendation contained in that report except as it may also be included in this chapter or other law~~)) Whenever feasible, the administrator shall reduce the administrative cost of operating the program by adopting joint policies or procedures applicable to both the basic health plan and employee health plans.

Sec. 212. RCW 70.47.060 and 1992 c 232 s 908 are each amended to read as follows:

ADMINISTRATOR'S POWERS AND DUTIES. The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be necessary for basic health care, which subsidized and nonsubsidized enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care and shall include all services necessary for prenatal, postnatal, and well-child care. However, ((~~for the period ending June 30, 1993,~~)) with respect to coverage for groups of subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for ((~~prenatal or postnatal~~)) such services ((~~that are provided under the medical assistance program under chapter 74.09 RCW~~)) except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider((~~, or except to provide any such services associated with pregnancies diagnosed by the managed care provider before July 1, 1992~~)). The schedule of services shall also include a separate schedule of basic health care services for children, eighteen years of age and younger, for those

subsidized or nonsubsidized enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.42.080, and such other factors as the administrator deems appropriate. On or after July 1, 1995, the uniform benefits package adopted and from time to time revised by the Washington health services commission pursuant to section 448 of this act shall be implemented by the administrator as the schedule of covered basic health care services. However, with respect to coverage for subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that the services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider.

(2)(a) To design and implement a structure of periodic premiums due the administrator from subsidized enrollees that is based upon gross family income, giving appropriate consideration to family size ((~~as well as~~)) and the ages of all family members. The enrollment of children shall not require the enrollment of their parent or parents who are eligible for the plan. The structure of periodic premiums shall be applied to subsidized enrollees entering the plan as individuals pursuant to subsection (9) of this section and to the share of the cost of the plan due from subsidized enrollees entering the plan as employees pursuant to subsection (10) of this section.

(b) To determine the periodic premiums due the administrator from nonsubsidized enrollees. Premiums due from nonsubsidized enrollees shall be in an amount equal to the cost charged by the managed health care system provider to the state for the plan plus the administrative cost of providing the plan to those enrollees and the appropriate premium tax as provided by law.

(c) An employer or other financial sponsor may, with the prior approval of the administrator, pay the premium, rate, or any other amount on behalf of a subsidized or nonsubsidized enrollee, by arrangement with the enrollee and through a mechanism acceptable to the administrator, but in no case shall the payment made on behalf of the enrollee exceed ninety-five percent of the total premiums due from the enrollee.

1 (d) On or after July 1, 1995, the administrator shall comply with
2 any schedule of premiums that may be adopted by the Washington health
3 services commission.
4 (3) To design and implement a structure of ((~~nominal~~)) copayments
5 due a managed health care system from subsidized and nonsubsidized
6 enrollees. The structure shall discourage inappropriate enrollee
7 utilization of health care services, but shall not be so costly to
8 enrollees as to constitute a barrier to appropriate utilization of
9 necessary health care services. On or after July 1, 1995, the
10 administrator shall comply with schedules of enrollee point of service
11 cost-sharing adopted by the Washington health services commission.
12 (4) ((~~To design and implement, in concert with a sufficient number~~
13 ~~of potential providers in a discrete area, an enrollee financial~~
14 ~~participation structure, separate from that otherwise established under~~
15 ~~this chapter, that has the following characteristics:~~
16 ~~(a) Nominal premiums that are based upon ability to pay, but not~~
17 ~~set at a level that would discourage enrollment;~~
18 ~~(b) A modified fee-for-services payment schedule for providers;~~
19 ~~(c) Coinsurance rates that are established based on specific~~
20 ~~service and procedure costs and the enrollee's ability to pay for the~~
21 ~~care. However, coinsurance rates for families with incomes below one~~
22 ~~hundred twenty percent of the federal poverty level shall be nominal.~~
23 ~~No coinsurance shall be required for specific proven prevention~~
24 ~~programs, such as prenatal care. The coinsurance rate levels shall not~~
25 ~~have a measurable negative effect upon the enrollee's health status;~~
26 ~~and~~
27 ~~(d) A case management system that fosters a provider-enrollee~~
28 ~~relationship whereby, in an effort to control cost, maintain or improve~~
29 ~~the health status of the enrollee, and maximize patient involvement in~~
30 ~~her or his health care decision-making process, every effort is made by~~
31 ~~the provider to inform the enrollee of the cost of the specific~~
32 ~~services and procedures and related health benefits.~~
33 ~~The potential financial liability of the plan to any such providers~~
34 ~~shall not exceed in the aggregate an amount greater than that which~~
35 ~~might otherwise have been incurred by the plan on the basis of the~~
36 ~~number of enrollees multiplied by the average of the prepaid capitated~~
37 ~~rates negotiated with participating managed health care systems under~~
38 ~~RCW 70.47.100 and reduced by any sums charged enrollees on the basis of~~
39 ~~the coinsurance rates that are established under this subsection.~~

~~(5)~~)) To limit enrollment of persons who qualify for subsidies so as to prevent an overexpenditure of appropriations for such purposes. Whenever the administrator finds that there is danger of such an overexpenditure, the administrator shall close enrollment until the administrator finds the danger no longer exists.

(5) To limit the payment of subsidies to subsidized enrollees, as defined in RCW 70.47.020.

(6) To adopt a schedule for the orderly development of the delivery of services and availability of the plan to residents of the state, subject to the limitations contained in RCW 70.47.080 or any act appropriating funds for the plan.

((~~In the selection of any area of the state for the initial operation of the plan, the administrator shall take into account the levels and rates of unemployment in different areas of the state, the need to provide basic health care coverage to a population reasonably representative of the portion of the state's population that lacks such coverage, and the need for geographic, demographic, and economic diversity.~~

~~Before July 1, 1988, the administrator shall endeavor to secure participation contracts with managed health care systems in discrete geographic areas within at least five congressional districts.~~))

(7) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state. Contracts with participating managed health care systems shall ensure that basic health plan enrollees who become eligible for medicaid, may, at their option, continue to receive services from their existing providers within the managed health care system if such providers have entered into provider agreements with the department of social and health services.

(8) To receive periodic premiums from or on behalf of subsidized and nonsubsidized enrollees, deposit them in the basic health plan operating account, keep records of enrollee status, and authorize periodic payments to managed health care systems on the basis of the number of enrollees participating in the respective managed health care systems.

(9) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan as subsidized or nonsubsidized enrollees, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and at least ((~~annually~~)) semiannually thereafter, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. ((~~An enrollee who remains current in payment of the sliding-scale premium, as determined under subsection (2) of this section, and whose gross family income has risen above twice the federal poverty level, may continue enrollment unless and until the enrollee's gross family income has remained above twice the poverty level for six consecutive months, by making payment at the unsubsidized rate required for the managed health care system in which he or she may be enrolled.~~)) No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If, as a result of an eligibility review, the administrator determines that a subsidized enrollee's income exceeds twice the federal poverty level and that the enrollee knowingly failed to inform the plan of such increase in income, the administrator may bill the enrollee for the subsidy paid on the enrollee's behalf during the period of time that the enrollee's income exceeded twice the federal poverty level. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to re-enroll in the plan.

(10) To accept applications from small business owners on behalf of themselves and their employees, spouses, and dependent children, as subsidized or nonsubsidized enrollees, who reside in an area served by the plan. The administrator may require all or the substantial majority of the eligible employees of such businesses to enroll in the

plan and establish those procedures necessary to facilitate the orderly enrollment of groups in the plan and into a managed health care system. The administrator shall require that a small business owner pay at least fifty percent but not more than ninety-five percent of the nonsubsidized premium cost of the plan on behalf of each employee enrolled in the plan. Effective on or after July 1, 1997, the employer participation levels established by the health services commission pursuant to section 455 of this act shall govern employer participation levels under this section. For the purposes of this subsection, an employee means an individual who regularly works for the small business for at least twenty hours per week. The businesses may have no more than one hundred employees at the time of initial enrollment and enrollment is limited to those not eligible for medicare or medical assistance, who wish to enroll in the plan and choose to obtain the basic health care coverage and services from a managed care system participating in the plan. The administrator shall adjust the amount determined to be due on behalf of or from all such enrollees whenever the amount negotiated by the administrator with the participating managed health care system or systems is modified or the administrative cost of providing the plan to such enrollees changes.

(11) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same for similar enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with participating systems, the administrator shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant.

(((11))) (12) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health

care systems, including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the managed health care systems and to the ((~~administrator~~)) plan. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the department of health, to minimize duplication of effort.

((~~(12) To monitor the access that state residents have to adequate and necessary health care services, determine the extent of any unmet needs for such services or lack of access that may exist from time to time, and make such reports and recommendations to the legislature as the administrator deems appropriate.~~))

(13) To evaluate the effects this chapter has on private employer-based health care coverage and to take appropriate measures consistent with state and federal statutes that will discourage the reduction of such coverage in the state.

(14) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

(15) ((~~To provide, consistent with available resources, technical assistance for rural health activities that endeavor to develop needed health care services in rural parts of the state~~)) To endeavor to expand enrollment as much as possible to correspond to the proportion of persons of color in the community served using the best available data that estimates representation of persons of color and describe these efforts in its annual report.

Sec. 213. RCW 70.47.080 and 1987 1st ex.s. c 5 s 10 are each amended to read as follows:

ENROLLMENT. On and after July 1, 1988, the administrator shall accept for enrollment applicants eligible to receive covered basic health care services from the respective managed health care systems which are then participating in the plan. ((~~The administrator shall not allow the total enrollment of those eligible for subsidies to exceed thirty thousand.~~))

Thereafter, total ((~~enrollment shall not exceed the number established by the legislature in any act appropriating funds to the plan.~~

~~Before July 1, 1988, the administrator shall endeavor to secure participation contracts from managed health care systems in discrete~~

~~geographic areas within at least five congressional districts of the state and in such manner as to allow residents of both urban and rural areas access to enrollment in the plan. The administrator shall make a special effort to secure agreements with health care providers in one such area that meets the requirements set forth in RCW 70.47.060(4)~~)) subsidized enrollment shall not result in expenditures that exceed the total amount that has been made available by the legislature in any act appropriating funds to the plan. To the extent that new funding is appropriated for expansion, the administrator shall endeavor to secure participation contracts from managed health care systems in geographic areas of the state that are unserved by the plan at the time at which the new funding is appropriated.

The administrator shall at all times closely monitor growth patterns of enrollment so as not to exceed that consistent with the orderly development of the plan as a whole, in any area of the state or in any participating managed health care system. The annual or biennial enrollment limitations derived from operation of the plan under this section do not apply to nonsubsidized enrollees as defined in RCW 70.47.020(5).

B. EXPANDED MANAGED CARE FOR STATE EMPLOYEES

Sec. 214. RCW 41.05.011 and 1990 c 222 s 2 are each amended to read as follows:

DEFINITIONS. Unless the context clearly requires otherwise, the definitions in this section shall apply throughout this chapter.

(1) "Administrator" means the administrator of the authority.

(2) "State purchased health care" or "health care" means medical and health care, pharmaceuticals, and medical equipment purchased with state and federal funds by the department of social and health services, the department of health, the basic health plan, the state health care authority, the department of labor and industries, the department of corrections, the department of veterans affairs, and local school districts.

(3) "Authority" means the Washington state health care authority.

(4) "Insuring entity" means an ((~~insurance carrier as defined in chapter 48.21 or 48.22~~)) insurer as defined in chapter 48.01 RCW, a health care service contractor as defined in chapter 48.44 RCW, or a health maintenance organization as defined in chapter 48.46 RCW. On

and after July 1, 1997, "insuring entity" means a certified health plan, as defined in section 402 of this act.

(5) "Flexible benefit plan" means a benefit plan that allows employees to choose the level of health care coverage provided and the amount of employee contributions from among a range of choices offered by the authority.

(6) "Employee" includes all full-time and career seasonal employees of the state, whether or not covered by civil service; upon a determination by the administrator as provided in RCW 41.05.021(2), all full-time employees of school districts; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; and includes any or all part-time and temporary employees under the terms and conditions established under this chapter by the authority; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature or of the legislative authority of any county, city, or town who are elected to office after February 20, 1970. "Employee" also includes employees of a county, municipality, or other political subdivision of the state if the legislative authority of the county, municipality, or other political subdivision of the state seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205((~~, and employees of a school district if the board of directors of the school district seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority as provided in RCW 28A.400.350~~)) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, upon the determination provided for in RCW 41.05.021(2) by the administrator, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization.

(7) "Board" means the ((~~state~~)) public employees' benefits board established under RCW 41.05.055.

Sec. 215. RCW 41.05.021 and 1990 c 222 s 3 are each amended to read as follows:

HEALTH CARE AUTHORITY DUTIES. (1) The Washington state health care authority is created within the executive branch. The authority shall have an administrator appointed by the governor, with the consent of the senate. The administrator shall serve at the pleasure of the governor. The administrator may employ up to seven staff members, who shall be exempt from chapter 41.06 RCW, and any additional staff members as are necessary to administer this chapter. The primary duties of the authority shall be to administer state employees' insurance benefits ((~~and to~~)), study state-purchased health care programs in order to maximize cost containment in these programs while ensuring access to quality health care, and implement state initiatives, joint purchasing strategies, and techniques for efficient administration that have potential application to all state-purchased health services. The authority's duties include, but are not limited to, the following:

((~~(1)~~)) (a) To administer a health care benefit program for employees as specifically authorized in RCW 41.05.065 and in accordance with the methods described in RCW 41.05.075, 41.05.140, and other provisions of this chapter;

((~~(2)~~)) (b) To analyze state-purchased health care programs and to explore options for cost containment and delivery alternatives for those programs that are consistent with the purposes of those programs, including, but not limited to:

((~~(a)~~)) (i) Creation of economic incentives for the persons for whom the state purchases health care to appropriately utilize and purchase health care services, including the development of flexible benefit plans to offset increases in individual financial responsibility;

((~~(b)~~)) (ii) Utilization of provider arrangements that encourage cost containment and ensure access to quality care, including but not limited to prepaid delivery systems, utilization review, and prospective payment methods;

((~~(c)~~)) (iii) Coordination of state agency efforts to purchase drugs effectively as provided in RCW 70.14.050;

((~~(d)~~)) (iv) Development of recommendations and methods for purchasing medical equipment and supporting services on a volume discount basis; and

((~~(e)~~)) (v) Development of data systems to obtain utilization data from state-purchased health care programs in order to identify cost

centers, utilization patterns, provider and hospital practice patterns, and procedure costs, utilizing the information obtained pursuant to RCW 41.05.031;

((~~(3)~~)) (c) To analyze areas of public and private health care interaction;

((~~(4)~~)) (d) To provide information and technical and administrative assistance to the board;

((~~(5)~~)) (e) To review and approve or deny applications from counties, municipalities, and other political subdivisions of the state((~~, and school districts~~)) to provide state-sponsored insurance or self-insurance programs to their employees in accordance with the provisions of RCW 41.04.205 ((~~and 28A.400.350~~)), setting the premium contribution for approved groups as outlined in RCW 41.05.050;

((~~(6)~~)) (f) To appoint a health care policy technical advisory committee as required by RCW 41.05.150; and

((~~(7)~~)) (g) To promulgate and adopt rules consistent with this chapter as described in RCW 41.05.160.

(2) The administrator shall determine the year in which the public employees' benefits board will undertake design and approval of insurance benefits plans for school district employees. Upon making that determination the administrator shall:

(a) Provide written notification to the fiscal committees of the senate and the house of representatives. Such notification shall be given by January 1 of the year prior to which the administrator will begin purchasing insurance benefits on behalf of school district employees; and

(b) Develop procedures necessary to ensure that the transition to insurance benefits purchasing by the administrator does not disrupt existing insurance contracts between school district employees and insurers.

(3) The public employees' benefits board shall implement strategies to promote managed competition among employee health benefit plans by January 1, 1995, including but not limited to:

(a) Standardizing the benefit package;

(b) Soliciting competitive bids for the benefit package;

(c) Limiting the state's contribution to a percent of the lowest priced sealed bid of a qualified plan within a geographical area. If the state's contribution is less than one hundred percent of the lowest

priced sealed bid, employee financial contributions shall be structured on a sliding-scale basis related to household income;

(d) Ensuring access to quality health services, including assuring reasonable access to local providers, especially for enrollees residing in rural areas;

(e) Monitoring the impact of the approach under this subsection with regards to: Efficiencies in health service delivery, cost shifts to subscribers, access to and choice of managed care plans state-wide, and quality of health services. The health care authority shall also advise on the value of administering a benchmark employer-managed plan to promote competition among managed care plans. The health care authority shall report its findings and recommendations to the legislature by January 1, 1997.

Sec. 216. RCW 41.05.050 and 1988 c 107 s 18 are each amended to read as follows:

FERRY EMPLOYEES. (1) Every department, division, or separate agency of state government, and such county, municipal, or other political subdivisions as are covered by this chapter, shall provide contributions to insurance and health care plans for its employees and their dependents, the content of such plans to be determined by the authority. Contributions, paid by the county, the municipality, or other political subdivision for their employees, shall include an amount determined by the authority to pay such administrative expenses of the authority as are necessary to administer the plans for employees of those groups. All such contributions will be paid into the ((~~state~~)) public employees' health insurance account.

(2) The contributions of any department, division, or separate agency of the state government, and such county, municipal, or other political subdivisions as are covered by this chapter, shall be set by the authority, subject to the approval of the governor for availability of funds as specifically appropriated by the legislature for that purpose. ((~~However,~~)) Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270 until December 31, 1996. On and after January 1, 1997, ferry employees shall enroll with certified health plans under chapter . . ., Laws of 1993 (this act).

(3) The administrator with the assistance of the ((~~state~~)) public employees' benefits board shall survey private industry and public employers in the state of Washington to determine the average employer

contribution for group insurance programs under the jurisdiction of the authority. Such survey shall be conducted during each even-numbered year but may be conducted more frequently. The survey shall be reported to the authority for its use in setting the amount of the recommended employer contribution to the employee insurance benefit program covered by this chapter. The authority shall transmit a recommendation for the amount of the employer contribution to the governor and the director of financial management for inclusion in the proposed budgets submitted to the legislature.

Sec. 217. RCW 41.05.055 and 1989 c 324 s 1 are each amended to read as follows:

SCHOOL DISTRICT EMPLOYEES. (1) The ((~~state~~)) public employees' benefits board is created within the authority. The function of the board is to design and approve insurance benefit plans for state employees and upon a determination by the administrator as provided in RCW 41.05.021(2), school district employees.

(2) Beginning in the year in which the administrator determines that the public employees' benefits board will undertake design and approval of insurance benefits plans for school district employees, as provided in RCW 41.05.021(2), the board shall be composed of ((~~seven~~)) nine members appointed by the governor as follows:

(a) ((~~Three~~)) Two representatives of state employees, ((~~one of whom shall represent an employee association certified as exclusive representative of at least one bargaining unit of classified employees,~~)) one of whom shall represent an employee union certified as exclusive representative of at least one bargaining unit of classified employees, and one of whom is retired, is covered by a program under the jurisdiction of the board, and represents an organized group of retired public employees;

(b) Two representatives of school district employees, one of whom shall represent an association of school employees and one of whom is retired, and represents an organized group of retired school employees;

((~~Three~~)) (c) Four members with experience in health benefit management and cost containment; and

((~~(c)~~)) (d) The administrator.

Prior to that year, the composition of the public employees benefits board shall reflect its composition on January 1, 1993.

1 (3) The governor shall appoint the initial members of the board to
2 staggered terms not to exceed four years. Members appointed thereafter
3 shall serve two-year terms. Members of the board shall be compensated
4 in accordance with RCW 43.03.250 and shall be reimbursed for their
5 travel expenses while on official business in accordance with RCW
6 43.03.050 and 43.03.060. The board shall prescribe rules for the
7 conduct of its business. The administrator shall serve as chair of the
8 board. Meetings of the board shall be at the call of the chair.

9 **Sec. 218.** RCW 41.05.065 and 1988 c 107 s 8 are each amended to
10 read as follows:
11 EMPLOYEE BENEFIT PLANS--STANDARDS. (1) The board shall study all
12 matters connected with the provision of health care coverage, life
13 insurance, liability insurance, accidental death and dismemberment
14 insurance, and disability income insurance or any of, or a combination
15 of, the enumerated types of insurance for employees and their
16 dependents on the best basis possible with relation both to the welfare
17 of the employees and to the state((~~: PROVIDED, That~~))<u>, however</u>
18 liability insurance shall not be made available to dependents.
19 (2) The ((~~state~~)) <u>public</u> employees' benefits board shall develop
20 employee benefit plans that include comprehensive health care benefits
21 for all employees. In developing these plans, the board shall consider
22 the following elements:
23 (a) Methods of maximizing cost containment while ensuring access to
24 quality health care;
25 (b) Development of provider arrangements that encourage cost
26 containment and ensure access to quality care, including but not
27 limited to prepaid delivery systems and prospective payment methods;
28 (c) Wellness incentives that focus on proven strategies, such as
29 smoking cessation, exercise, ((~~and~~)) automobile and motorcycle safety<u>,</u>
30 <u>blood cholesterol reduction, and nutrition education</u>;
31 (d) Utilization review procedures including, but not limited to
32 prior authorization of services, hospital inpatient length of stay
33 review, requirements for use of outpatient surgeries and second
34 opinions for surgeries, review of invoices or claims submitted by
35 service providers, and performance audit of providers; ((~~and~~))
36 (e) Effective coordination of benefits<u>;</u>
37 <u>(f) Minimum standards for insuring entities; and</u>

(g) Minimum scope and content of standard benefit plans to be offered to enrollees participating in the employee health benefit plans. On and after July 1, 1995, the uniform benefits package shall constitute the minimum level of health benefits offered to employees. To maintain the comprehensive nature of employee health care benefits, the benefits provided to employees shall be substantially equivalent to the state employees' health benefits plan in effect on January 1, 1993.

(3) The board shall design benefits and determine the terms and conditions of employee participation and coverage, including establishment of eligibility criteria.

(4) The board shall attempt to achieve enrollment of all employees and retirees in managed health care systems by July 1994.

The board may authorize premium contributions for an employee and the employee's dependents in a manner that encourages the use of cost-efficient managed health care systems. ((~~Such authorization shall require a vote of five members of the board for approval.~~))

(5) Employees ((~~may~~)) shall choose participation in only one of the health care benefit plans developed by the board.

(6) The board shall review plans proposed by insurance carriers that desire to offer property insurance and/or accident and casualty insurance to state employees through payroll deduction. The board may approve any such plan for payroll deduction by carriers holding a valid certificate of authority in the state of Washington and which the board determines to be in the best interests of employees and the state. The board shall promulgate rules setting forth criteria by which it shall evaluate the plans.

Sec. 219. RCW 41.05.120 and 1991 sp.s. c 13 s 100 are each amended to read as follows:

PUBLIC EMPLOYEES' INSURANCE ACCOUNT. (1) The ((~~state~~)) public employees' insurance account is hereby established in the custody of the state treasurer, to be used by the administrator for the deposit of contributions, reserves, dividends, and refunds, and for payment of premiums for employee insurance benefit contracts. Moneys from the account shall be disbursed by the state treasurer by warrants on vouchers duly authorized by the administrator.

(2) The state treasurer and the state investment board may invest moneys in the ((~~state~~)) public employees' insurance account. All such investments shall be in accordance with RCW 43.84.080 or 43.84.150,

1 whichever is applicable. The administrator shall determine whether the
2 state treasurer or the state investment board or both shall invest
3 moneys in the ((~~state~~)) <u>public</u> employees' insurance account.

4 **Sec. 220.** RCW 41.05.140 and 1988 c 107 s 12 are each amended to
5 read as follows:
6 PUBLIC EMPLOYEES' INSURANCE RESERVE FUND. (1) The authority may
7 self-fund or self-insure for public employees' benefits plans, but
8 shall also enter into other methods of providing insurance coverage for
9 insurance programs under its jurisdiction except property and casualty
10 insurance. The authority shall contract for payment of claims or other
11 administrative services for programs under its jurisdiction. If a
12 program does not require the prepayment of reserves, the authority
13 shall establish such reserves within a reasonable period of time for
14 the payment of claims as are normally required for that type of
15 insurance under an insured program. Reserves established by the
16 authority shall be held in a separate trust fund by the state treasurer
17 and shall be known as the ((~~state~~)) <u>public</u> employees' insurance reserve
18 fund. The state investment board shall act as the investor for the
19 funds and, except as provided in RCW 43.33A.160, one hundred percent of
20 all earnings from these investments shall accrue directly to the
21 ((~~state~~)) <u>public</u> employees' insurance reserve fund.
22 (2) Any savings realized as a result of a program created under
23 this section shall not be used to increase benefits unless such use is
24 authorized by statute.
25 (3) Any program created under this section shall be subject to the
26 examination requirements of chapter 48.03 RCW as if the program were a
27 domestic insurer. In conducting an examination, the commissioner shall
28 determine the adequacy of the reserves established for the program.
29 (4) The authority shall keep full and adequate accounts and records
30 of the assets, obligations, transactions, and affairs of any program
31 created under this section.
32 (5) The authority shall file a quarterly statement of the financial
33 condition, transactions, and affairs of any program created under this
34 section in a form and manner prescribed by the insurance commissioner.
35 The statement shall contain information as required by the commissioner
36 for the type of insurance being offered under the program. A copy of
37 the annual statement shall be filed with the speaker of the house of
38 representatives and the president of the senate.

NEW SECTION. **Sec. 221.** A new section is added to chapter 41.05 RCW to read as follows:

MEDICARE SUPPLEMENTAL BENEFITS. (1) Notwithstanding any other provisions of this chapter, if a waiver of the medicare statute, as provided in section 460 of this act, is not obtained prior to June 30, 1995, the administrator shall develop at least two medical plans for retirees eligible for medicare. One of the packages shall include coverage for prescription drugs. The packages shall be offered beginning July 1, 1996, and until a medicare waiver is obtained, to any resident of the state eligible for medicare benefits.

(2) The administrator may:

(a) Offer a self-funded medical plan for retirees eligible for medicare that includes all services available in the uniform benefits package to the extent they are not covered by medicare; and

(b) Offer medical plans for retirees eligible for medicare that conform to the requirements of chapter 48.66 RCW.

(3) The medical plans for retirees eligible for medicare shall be administered and shall have rates calculated as a distinct experience pool.

(4) To the extent that funding is made available specifically for this purpose, the administrator shall establish subsidies for low-income residents' premium and cost-sharing payments.

Sec. 222. RCW 47.64.270 and 1988 c 107 s 21 are each amended to read as follows:

Until December 31, 1996, absent a collective bargaining agreement to the contrary, the department of transportation shall provide contributions to insurance and health care plans for ferry system employees and dependents, as determined by the state health care authority, under chapter 41.05 RCW((~~:~~)); and the ferry system management and employee organizations may collectively bargain for other insurance and health care plans, and employer contributions may exceed that of other state agencies as provided in RCW 41.05.050, subject to RCW 47.64.180. On January 1, 1997, ferry employees shall enroll in certified health plans under the provisions of chapter . . ., Laws of 1993 (this act). To the extent that ferry employees by bargaining unit have absorbed the required offset of wage increases by the amount that the employer's contribution for employees' and dependents' insurance and health care plans exceeds that of other state

general government employees in the 1985-87 fiscal biennium, employees shall not be required to absorb a further offset except to the extent the differential between employer contributions for those employees and all other state general government employees increases during any subsequent fiscal biennium. If such differential increases in the 1987-89 fiscal biennium or the 1985-87 offset by bargaining unit is insufficient to meet the required deduction, the amount available for compensation shall be reduced by bargaining unit by the amount of such increase or the 1985-87 shortage in the required offset. Compensation shall include all wages and employee benefits.

Sec. 223. RCW 28A.400.200 and 1990 1st ex.s. c 11 s 2 and 1990 c 33 s 381 are each reenacted and amended to read as follows:

(1) Every school district board of directors shall fix, alter, allow, and order paid salaries and compensation for all district employees in conformance with this section.

(2)(a) Salaries for certificated instructional staff shall not be less than the salary provided in the appropriations act in the state-wide salary allocation schedule for an employee with a baccalaureate degree and zero years of service; and

(b) Salaries for certificated instructional staff with a masters degree shall not be less than the salary provided in the appropriations act in the state-wide salary allocation schedule for an employee with a masters degree and zero years of service;

(3)(a) The actual average salary paid to basic education certificated instructional staff shall not exceed the district's average basic education certificated instructional staff salary used for the state basic education allocations for that school year as determined pursuant to RCW 28A.150.410.

(b) Fringe benefit contributions for basic education certificated instructional staff shall be included as salary under (a) of this subsection only to the extent that the district's actual average benefit contribution exceeds the ((~~greater of: (i) The formula amount for insurance benefits~~)) amount of the insurance benefits allocation provided per certificated instructional staff unit in the state operating appropriations act in effect at the time the compensation is payable((~~; or (ii) the actual average amount provided by the school district in the 1986-87 school year~~)). For purposes of this section, fringe benefits shall not include payment for unused leave for illness

or injury under RCW 28A.400.210((~~, or~~))_;_ employer contributions for old age survivors insurance, workers' compensation, unemployment compensation, and retirement benefits under the Washington state retirement system_; or employer contributions for health benefits in excess of the insurance benefits allocation provided per certificated instructional staff unit in the state operating appropriations act in effect at the time the compensation is payable. A school district may not use state funds to provide employer contributions for such excess health benefits_.

(c) Salary and benefits for certificated instructional staff in programs other than basic education shall be consistent with the salary and benefits paid to certificated instructional staff in the basic education program.

(4) Salaries and benefits for certificated instructional staff may exceed the limitations in subsection (3) of this section only by separate contract for additional time, additional responsibilities, or incentives. Supplemental contracts shall not cause the state to incur any present or future funding obligation. Supplemental contracts shall be subject to the collective bargaining provisions of chapter 41.59 RCW and the provisions of RCW 28A.405.240, shall not exceed one year, and if not renewed shall not constitute adverse change in accordance with RCW 28A.405.300 through 28A.405.380. No district may enter into a supplemental contract under this subsection for the provision of services which are a part of the basic education program required by Article IX, section 3 of the state Constitution.

(5) Employee benefit plans offered by any district shall comply with RCW 28A.400.350 and 28A.400.275 and 28A.400.280.

Sec. 224. RCW 28A.400.350 and 1990 1st ex.s. c 11 s 3 and 1990 c 74 s 1 are each reenacted and amended to read as follows:

(1) The board of directors of any of the state's school districts may make available liability, life, health, health care, accident, disability and salary protection or insurance or any one of, or a combination of the enumerated types of insurance, or any other type of insurance or protection, for the members of the boards of directors, the students, and employees of the school district, and their dependents. Such coverage may be provided by contracts with private carriers, with the state health care authority after July 1, 1990, pursuant to the approval of the authority administrator, or through

1 self-insurance or self-funding pursuant to chapter 48.62 RCW, or in any
2 other manner authorized by law. <u>Except to the extent provided in RCW
3 28A.400.200, upon the making of a determination provided for in RCW
4 41.05.021(2) by the administrator of the state health care authority,
5 health care coverage, life insurance, liability insurance, accidental
6 death and dismemberment insurance, and disability income insurance
7 shall be provided only by contracts with the state health care
8 authority.</u>
9 (2) Whenever funds are available for these purposes the board of
10 directors of the school district may contribute all or a part of the
11 cost of such protection or insurance for the employees of their
12 respective school districts and their dependents. The premiums on such
13 liability insurance shall be borne by the school district.
14 After October 1, 1990, school districts may not contribute to any
15 employee protection or insurance other than liability insurance unless
16 the district's employee benefit plan conforms to RCW 28A.400.275 and
17 28A.400.280.
18 (3) For school board members and students, the premiums due on such
19 protection or insurance shall be borne by the assenting school board
20 member or student: PROVIDED, That the school district may contribute
21 all or part of the costs, including the premiums, of life, health,
22 health care, accident or disability insurance which shall be offered to
23 all students participating in interschool activities on the behalf of
24 or as representative of their school or school district. The school
25 district board of directors may require any student participating in
26 extracurricular interschool activities to, as a condition of
27 participation, document evidence of insurance or purchase insurance
28 that will provide adequate coverage, as determined by the school
29 district board of directors, for medical expenses incurred as a result
30 of injury sustained while participating in the extracurricular
31 activity. In establishing such a requirement, the district shall adopt
32 regulations for waiving or reducing the premiums of such coverage as
33 may be offered through the school district to students participating in
34 extracurricular activities, for those students whose families, by
35 reason of their low income, would have difficulty paying the entire
36 amount of such insurance premiums. The district board shall adopt
37 regulations for waiving or reducing the insurance coverage requirements
38 for low-income students in order to assure such students are not

prohibited from participating in extracurricular interschool activities.

(4) All contracts for insurance or protection written to take advantage of the provisions of this section shall provide that the beneficiaries of such contracts may utilize on an equal participation basis the services of those practitioners licensed pursuant to chapters 18.22, 18.25, 18.53, 18.57, and 18.71 RCW.

C. CONSOLIDATED STATE HEALTH CARE PURCHASING AGENT

NEW SECTION. **Sec. 225.** A new section is added to Title 43 RCW to read as follows:

STATE HEALTH SERVICES AGENT. (1) The health care authority is hereby designated as the single state agent for purchasing health services.

(2) On and after July 1, 1995, at least the following state-purchased health services programs shall be merged into a single, community-rated risk pool: The basic health plan; health benefits for active employees of school districts, to the extent that the administrator has made a determination under RCW 41.05.021(2); and health benefits for active state employees. Until that date, in purchasing health services, the health care authority shall maintain separate experience pools for each of the programs in this subsection. The administrator may develop mechanisms to ensure that the cost of comparable benefits packages does not vary widely across the experience pools. At the earliest opportunity the governor shall seek necessary federal waivers and state legislation to place the medical and acute care components of the medical assistance program, the limited casualty program, and the medical care services program of the department of social and health services in this single risk pool. Long-term care services that are provided under the medical assistance program shall not be placed in the single risk pool until such services have been added to the uniform benefits package. On or before January 1, 1997, the governor shall submit necessary legislation to place the purchasing of health benefits for persons incarcerated in institutions administered by the department of corrections into the single community-rated risk pool effective on and after July 1, 1997.

(3) At a minimum, and regardless of other legislative enactments, the state health services purchasing agent shall:

1 (a) Require that a public agency that provides subsidies for a
2 substantial portion of services now covered under the basic health plan
3 or a uniform benefits package as adopted by the Washington health
4 services commission as provided in section 448 of this act, use uniform
5 eligibility processes, insofar as may be possible, and ensure that
6 multiple eligibility determinations are not required;
7 (b) Require that a health care provider or a health care facility
8 that receives funds from a public program provide care to state
9 residents receiving a state subsidy who may wish to receive care from
10 them, and that a health maintenance organization, health care service
11 contractor, insurer, or certified health plan that receives funds from
12 a public program accept enrollment from state residents receiving a
13 state subsidy who may wish to enroll with them;
14 (c) Strive to integrate purchasing for all publicly sponsored
15 health services in order to maximize the cost control potential and
16 promote the most efficient methods of financing and coordinating
17 services;
18 (d) Annually suggest changes in state and federal law and rules to
19 bring all publicly funded health programs in compliance with the goals
20 and intent of chapter . . ., Laws of 1993 (this act);
21 (e) Consult regularly with the governor, the legislature, and state
22 agency directors whose operations are affected by the implementation of
23 this section;
24 (f) Ensure that procedures and due process guarantees no less
25 beneficial than those available under federal and state law to
26 participants in the medical assistance, limited casualty, and medical
27 care services programs are provided to all persons who, but for the
28 federal waivers and state legislation procured under subsection (1) of
29 this section, would be eligible for those programs.

30 NEW SECTION. **Sec. 226.** A new section is added to chapter 41.05
31 RCW to read as follows:
32 WASHINGTON STATE GROUP PURCHASING ASSOCIATION. (1) The Washington
33 state group purchasing association is established for the purpose of
34 coordinating and enhancing the health care purchasing power of the
35 groups identified in subsection (2) of this section. The purchasing
36 association shall be administered by the administrator.
37 (2) The following organizations or entities may seek the approval
38 of the administrator for membership in the purchasing association:

1 (a) Private nonprofit human services provider organizations under
2 contract with state agencies, on behalf of their employees and their
3 employees' spouses and dependent children;
4 (b) Individuals providing in-home long-term care services to
5 persons whose care is financed in whole or in part through the medical
6 assistance personal care or community options program entry system
7 program as provided in chapter 74.09 RCW, or the chore services
8 program, as provided in chapter 74.08 RCW, on behalf of themselves and
9 their spouses and dependent children;
10 (c) Owners and operators of child day care centers and family child
11 care homes licensed under chapter 74.15 RCW and of preschool or other
12 child care programs exempted from licensing under chapter 74.15 RCW on
13 behalf of themselves and their employees and employees' spouses and
14 dependent children; and
15 (d) Foster parents contracting with the department of social and
16 health services under chapter 74.13 RCW and licensed under chapter
17 74.15 RCW on behalf of themselves and their spouses and dependent
18 children.
19 (3) In administering the purchasing association, the administrator
20 shall:
21 (a) Negotiate and enter into contracts on behalf of the purchasing
22 association's members in conjunction with its contracting and
23 purchasing activities for employee benefit plans under RCW 41.05.075.
24 In negotiating and contracting with insuring entities on behalf of
25 employees and purchasing association members, distinct experience pools
26 shall be maintained.
27 (b) Review and approve or deny applications from entities seeking
28 membership in the purchasing association:
29 (i) The administrator may require all or the substantial majority
30 of the employees of the organizations or entities listed in subsection
31 (2) of this section to enroll in the purchasing association.
32 (ii) The administrator shall require, that as a condition of
33 membership in the purchasing association, an entity or organization
34 listed in subsection (2) of this section that employs individuals pay
35 at least fifty percent but not more than ninety-five percent of the
36 cost of the insurance coverage for each employee enrolled in the
37 purchasing association.

(iii) In offering and administering the purchasing association, the administrator may not discriminate against individuals or groups based on age, gender, geographic area, industry, or medical history.

(4) On or after July 1, 1995, the uniform benefits package and schedule of premiums and point of service cost-sharing adopted and from time to time revised by the health services commission pursuant to chapter . . ., Laws of 1993 (this act) shall be applicable to the association.

(5) The administrator shall adopt preexisting condition coverage provisions for the association as provided in sections 280 through 283 of this act.

(6)(a) The Washington state group purchasing association account is established in the custody of the state treasurer, to be used by the administrator for the deposit of premium payments from individuals and entities described in subsection (2) of this section, and for payment of premiums for benefit contracts entered into on behalf of the purchasing association's participants and operating expenses incurred by the authority in the administration of benefit contracts under this section. Moneys from the account shall be disbursed by the state treasurer by warrants on vouchers duly authorized by the administrator.

(b) Disbursements from the account are not subject to appropriations, but shall be subject to the allotment procedure provided under chapter 43.88 RCW.

NEW SECTION. **Sec. 227.** A new section is added to chapter 41.05 RCW to read as follows:

MARKETING PLAN. The administrator shall develop a marketing plan for the basic health plan and the Washington state group purchasing association. The plan shall be targeted to individuals and entities eligible to enroll in the two programs and provide clear and understandable explanations of the programs and enrollment procedures. The plan also shall incorporate special efforts to reach communities and people of color.

NEW SECTION. **Sec. 228.** WASHINGTON STATE GROUP PURCHASING ASSOCIATION--REPEAL. The following acts or parts of acts, as now existing or hereafter amended, are each repealed, effective June 30, 1998:

(1) RCW 41.05.___ and 1993 c ___ s 226 (section 226 of this act); and

(2) RCW 41.05.___ and 1993 c ___ s 227 (section 227 of this act).

NEW SECTION. **Sec. 229.** TRANSFER OF AUTHORITY TO PURCHASE SERVICES FROM COMMUNITY HEALTH CENTERS. (1) State general funds appropriated to the department of health for the purposes of funding community health centers to provide primary medical and dental care services, migrant health services, and maternity health care services shall be transferred to the state health care authority. Any related administrative funds expended by the department of health for this purpose shall also be transferred to the health care authority. The health care authority shall exclusively expend these funds through contracts with community health centers to provide primary medical and dental care services, migrant health services, and maternity health care services. The administrator of the health care authority shall establish requirements necessary to assure community health centers provide quality health care services that are appropriate and effective and are delivered in a cost-efficient manner. The administrator shall further assure that community health centers have appropriate referral arrangements for acute care and medical specialty services not provided by the community health centers.

(2) To further the intent of chapter . . ., Laws of 1993 (this act), the health care authority, in consultation with the department of health, shall evaluate the organization and operation of the federal and state-funded community health centers and other not-for-profit health care organizations and propose recommendations to the health services commission and the health policy committees of the legislature by November 30, 1994, that identify changes to permit community health centers and other not-for-profit health care organizations to form certified health plans or other innovative health care delivery arrangements that help ensure access to primary health care services consistent with the purposes of chapter . . ., Laws of 1993 (this act).

D. HEALTH CARE PROVIDER CONFLICT OF INTEREST STANDARDS

Sec. 230. RCW 19.68.010 and 1973 1st ex.s. c 26 s 1 are each amended to read as follows:

It shall be unlawful for any person, firm, corporation or association, whether organized as a cooperative, or for profit or nonprofit, to pay, or offer to pay or allow, directly or indirectly, to any person licensed by the state of Washington to engage in the practice of medicine and surgery, drugless treatment in any form, dentistry, or pharmacy and it shall be unlawful for such person to request, receive or allow, directly or indirectly, a rebate, refund, commission, unearned discount or profit by means of a credit or other valuable consideration in connection with the referral of patients to any person, firm, corporation or association, or in connection with the furnishings of medical, surgical or dental care, diagnosis, treatment or service, on the sale, rental, furnishing or supplying of clinical laboratory supplies or services of any kind, drugs, medication, or medical supplies, or any other goods, services or supplies prescribed for medical diagnosis, care or treatment: PROVIDED, That ownership of a financial interest in any firm, corporation or association which furnishes any kind of clinical laboratory or other services prescribed for medical, surgical, or dental diagnosis shall not be prohibited under this section where (1) the referring practitioner affirmatively discloses to the patient in writing, the fact that such practitioner has a financial interest in such firm, corporation, or association; and (2) the referring practitioner provides the patient with a list of effective alternative facilities, informs the patient that he or she has the option to use one of the alternative facilities, and assures the patient that he or she will not be treated differently by the referring practitioner if the patient chooses one of the alternative facilities.

Any person violating the provisions of this section is guilty of a misdemeanor.

E. PUBLIC HEALTH FINANCING AND GOVERNANCE

Sec. 231. RCW 70.05.010 and 1967 ex.s. c 51 s 1 are each amended to read as follows:

For the purposes of chapters 70.05 and 70.46 RCW ((~~and RCW 70.46.020 through 70.46.090~~)) and unless the context thereof clearly indicates to the contrary:

(1) "Local health departments" means the ((~~city, town,~~)) county or district which provides public health services to persons within the area;

(2) "Local health officer" means the legally qualified physician who has been appointed as the health officer for the ((~~city, town,~~)) county or district public health department;

(3) "Local board of health" means the ((~~city, town,~~)) county or district board of health.

(4) "Health district" means ((~~all territory encompassed within a single county and all cities and towns therein except cities with a population of over one hundred thousand, or~~)) all the territory consisting of one or more counties ((~~and all the cities and towns in all of the combined counties except cities of over one hundred thousand population which have been combined and~~)) organized pursuant to the provisions of chapters 70.05 and 70.46 RCW ((~~and RCW 70.46.020 through 70.46.090: PROVIDED, That cities with a population of over one hundred thousand may be included in a health district as provided in RCW 70.46.040~~)).

(5) "Department" means the department of health.

Sec. 232. RCW 70.05.030 and 1967 ex.s. c 51 s 3 are each amended to read as follows:

In counties without a home rule charter, the board of county commissioners ((~~of each and every county in this state, except where such county is a part of a health district or is purchasing services under a contract as authorized by chapter 70.05 RCW and RCW 70.46.020 through 70.46.090,~~)) shall constitute the local board of health ((~~for such county, and said local board of health's jurisdiction~~)), unless the county is part of a health district pursuant to chapter 70.46 RCW. The jurisdiction of the local board of health shall be coextensive with the boundaries of said county((~~, except that nothing herein contained shall give said board jurisdiction in cities of over one hundred thousand population or in such other cities and towns as are providing health services which meet health standards pursuant to RCW 70.46.090~~)).

Sec. 233. RCW 70.05.040 and 1984 c 25 s 1 are each amended to read as follows:

The local board of health shall elect a ((~~chairman~~)) chair and may appoint an administrative officer. A local health officer shall be appointed pursuant to RCW 70.05.050. Vacancies on the local board of health shall be filled by appointment within thirty days and made in the same manner as was the original appointment. At the first meeting of the local board of health, the members shall elect a ((~~chairman~~)) chair to serve for a period of one year. ((~~In home rule charter counties that have a local board of health established under RCW 70.05.050, the administrative officer may be appointed by the official designated under the county's charter.~~))

NEW SECTION. **Sec. 234.** A new section is added to chapter 70.05 RCW to read as follows:

In counties with a home rule charter, the county legislative authority shall establish a local board of health and may prescribe the membership and selection process for the board. The jurisdiction of the local board of health shall be coextensive with the boundaries of the county. The local health officer, as described in RCW 70.05.050, shall be appointed by the official designated under the provisions of the county charter. The same official designated under the provisions of the county charter may appoint an administrative officer, as described in RCW 70.05.045.

Sec. 235. RCW 70.05.050 and 1984 c 25 s 5 are each amended to read as follows:

((~~Each local board of health, other than boards which are established under RCW 70.05.030 and which are located in counties having home rule charters, shall appoint a local health officer. In home rule charter counties which have a local board of health established under RCW 70.05.030, the local health officer shall be appointed by the official designated under the provisions of the county's charter.~~))

The local health officer shall be an experienced physician licensed to practice medicine and surgery or osteopathy and surgery in this state and who is qualified or provisionally qualified in accordance with the standards prescribed in RCW 70.05.051 through 70.05.055 to hold the office of local health officer. No term of office shall be established for the local health officer but ((~~he~~)) the local health officer shall not be removed until after notice is given ((~~him~~)), and

an opportunity for a hearing before the board or official responsible for his or her appointment under this section as to the reason for his or her removal. ((~~He~~)) The local health officer shall act as executive secretary to, and administrative officer for the local board of health and shall also be empowered to employ such technical and other personnel as approved by the local board of health except where the local board of health has appointed an administrative officer under RCW 70.05.040. The local health officer shall be paid such salary and allowed such expenses as shall be determined by the local board of health.

Sec. 236. RCW 70.05.070 and 1991 c 3 s 309 are each amended to read as follows:

The local health officer, acting under the direction of the local board of health or under direction of the administrative officer appointed under RCW 70.05.040 or section 234 of this act, if any, shall:

(1) Enforce the public health statutes of the state, rules of the state board of health and the secretary of health, and all local health rules, regulations and ordinances within his or her jurisdiction including imposition of penalties authorized under RCW 70.119A.030 and filing of actions authorized by RCW 43.70.190;

(2) Take such action as is necessary to maintain health and sanitation supervision over the territory within his or her jurisdiction;

(3) Control and prevent the spread of any dangerous, contagious or infectious diseases that may occur within his or her jurisdiction;

(4) Inform the public as to the causes, nature, and prevention of disease and disability and the preservation, promotion and improvement of health within his or her jurisdiction;

(5) Prevent, control or abate nuisances which are detrimental to the public health;

(6) Attend all conferences called by the secretary of health or his or her authorized representative;

(7) Collect such fees as are established by the state board of health or the local board of health for the issuance or renewal of licenses or permits or such other fees as may be authorized by law or by the rules of the state board of health;

(8) Inspect, as necessary, expansion or modification of existing public water systems, and the construction of new public water systems, to assure that the expansion, modification, or construction conforms to system design and plans;

(9) Take such measures as he or she deems necessary in order to promote the public health, to participate in the establishment of health educational or training activities, and to authorize the attendance of employees of the local health department or individuals engaged in community health programs related to or part of the programs of the local health department.

Sec. 237. RCW 70.05.080 and 1991 c 3 s 310 are each amended to read as follows:

If the local board of health or other official responsible for appointing a local health officer under RCW 70.05.050 refuses or neglects to appoint a local health officer after a vacancy exists, the secretary of health may appoint a local health officer and fix the compensation. The local health officer so appointed shall have the same duties, powers and authority as though appointed under RCW 70.05.050. Such local health officer shall serve until a qualified individual is appointed according to the procedures set forth in RCW 70.05.050. The board or official responsible for appointing the local health officer under RCW 70.05.050 shall also be authorized to appoint an acting health officer to serve whenever the health officer is absent or incapacitated and unable to fulfill his or her responsibilities under the provisions of chapters 70.05 and 70.46 RCW ((~~and RCW 70.46.020 through 70.46.090~~)).

Sec. 238. RCW 70.05.120 and 1984 c 25 s 8 are each amended to read as follows:

Any local health officer or administrative officer appointed under RCW 70.05.040, if any, who shall refuse or neglect to obey or enforce the provisions of chapters 70.05 and 70.46 RCW ((~~and RCW 70.46.020 through 70.46.090~~)) or the rules, regulations or orders of the state board of health or who shall refuse or neglect to make prompt and accurate reports to the state board of health, may be removed as local health officer or administrative officer by the state board of health and shall not again be reappointed except with the consent of the state board of health. Any person may complain to the state board of health

1 concerning the failure of the local health officer or administrative
2 officer to carry out the laws or the rules and regulations concerning
3 public health, and the state board of health shall, if a preliminary
4 investigation so warrants, call a hearing to determine whether the
5 local health officer or administrative officer is guilty of the alleged
6 acts. Such hearings shall be held pursuant to the provisions of
7 chapter 34.05 RCW, and the rules and regulations of the state board of
8 health adopted thereunder.

9 Any member of a local board of health who shall violate any of the
10 provisions of chapters 70.05 and 70.46 RCW ((~~and RCW 70.46.020 through~~
11 ~~70.46.090~~)) or refuse or neglect to obey or enforce any of the rules,
12 regulations or orders of the state board of health made for the
13 prevention, suppression or control of any dangerous contagious or
14 infectious disease or for the protection of the health of the people of
15 this state, shall be guilty of a misdemeanor, and upon conviction shall
16 be fined not less than ten dollars nor more than two hundred dollars.
17 Any physician who shall refuse or neglect to report to the proper
18 health officer or administrative officer within twelve hours after
19 first attending any case of contagious or infectious disease or any
20 diseases required by the state board of health to be reported or any
21 case suspicious of being one of such diseases, shall be guilty of a
22 misdemeanor, and upon conviction shall be fined not less than ten
23 dollars nor more than two hundred dollars for each case that is not
24 reported.

25 Any person violating any of the provisions of chapters 70.05 and
26 70.46 RCW ((~~and RCW 70.46.020 through 70.46.090~~)) or violating or
27 refusing or neglecting to obey any of the rules, regulations or orders
28 made for the prevention, suppression and control of dangerous
29 contagious and infectious diseases by the local board of health or
30 local health officer or administrative officer or state board of
31 health, or who shall leave any isolation hospital or quarantined house
32 or place without the consent of the proper health officer or who evades
33 or breaks quarantine or conceals a case of contagious or infectious
34 disease or assists in evading or breaking any quarantine or concealing
35 any case of contagious or infectious disease, shall be guilty of a
36 misdemeanor, and upon conviction thereof shall be subject to a fine of
37 not less than twenty-five dollars nor more than one hundred dollars or
38 to imprisonment in the county jail not to exceed ninety days or to both
39 fine and imprisonment.

Sec. 239. RCW 70.05.130 and 1991 c 3 s 313 are each amended to read as follows:

All expenses incurred by the state, health district, or county in carrying out the provisions of chapters 70.05 and 70.46 RCW ((~~and RCW 70.46.020 through 70.46.090~~)) or any other public health law, or the rules of the ((~~state~~)) department of health enacted under such laws, shall be paid by the county ((~~or city by which or in behalf of which such expenses shall have been incurred~~)) and such expenses shall constitute a claim against the general fund as provided herein.

Sec. 240. RCW 70.05.150 and 1967 ex.s. c 51 s 22 are each amended to read as follows:

In addition to powers already granted them, any ((~~city, town,~~)) county, district, or local health department may contract for either the sale or purchase of any or all health services from any local health department: PROVIDED, That such contract shall require the approval of the state board of health.

Sec. 241. RCW 70.08.010 and 1985 c 124 s 1 are each amended to read as follows:

Any city with one hundred thousand or more population and the county in which it is located, are authorized, as shall be agreed upon between the respective governing bodies of such city and said county, to establish and operate a combined city and county health department, and to appoint ((~~the director of public health~~)) a local health officer for the county served. Class AA counties may appoint a director of public health as specified in this chapter.

Sec. 242. RCW 70.12.030 and 1945 c 46 s 1 are each amended to read as follows:

Any county, ((~~first class city~~)) combined city-county health department, or health district is hereby authorized and empowered to create a "public health pooling fund", hereafter called the "fund", for the efficient management and control of all moneys coming to such county, ((~~first class city~~)) combined department, or district for public health purposes.

((~~"Health district" as used herein may mean all territory consisting of one or more counties and all cities with a population of one hundred thousand or less, and towns therein.~~))

Sec. 243. RCW 70.12.050 and 1945 c 46 s 3 are each amended to read as follows:

All expenditures in connection with salaries, wages and operations incurred in carrying on the health department of the county, ((~~first class city~~)) combined city-county health department, or health district shall be paid out of such fund.

Sec. 244. RCW 70.46.020 and 1967 ex.s. c 51 s 6 are each amended to read as follows:

Health districts consisting of two or more counties may be created whenever two or more boards of county commissioners shall by resolution establish a district for such purpose. Such a district shall consist of all the area of the combined counties ((~~including all cities and towns except cities of over one hundred thousand population~~)). The district board of health of such a district shall consist of not less than five members for districts of two counties and seven members for districts of more than two counties, including two representatives from each county who are members of the board of county commissioners and who are appointed by the board of county commissioners of each county within the district, and shall have a jurisdiction coextensive with the combined boundaries. ((~~The remaining members shall be representatives of the cities and towns in the district selected by mutual agreement of the legislative bodies of the cities and towns concerned from their membership, taking into consideration the financial contribution of such cities and towns and representation from the several classifications of cities and towns.~~))

At the first meeting of a district board of health the members shall elect a ((~~chairman~~)) chair to serve for a period of one year.

Sec. 245. RCW 70.46.060 and 1967 ex.s. c 51 s 11 are each amended to read as follows:

The district board of health shall constitute the local board of health for all the territory included in the health district, and shall supersede and exercise all the powers and perform all the duties by law vested in the county ((~~or city or town~~)) board of health of any county((~~, city or town~~)) included in the health district((~~, except as otherwise in chapter 70.05 RCW and RCW 70.46.020 through 70.46.090 provided~~)).

Sec. 246. RCW 70.46.080 and 1971 ex.s. c 85 s 10 are each amended to read as follows:

Each health district shall establish a fund to be designated as the "district health fund", in which shall be placed all sums received by the district from any source, and out of which shall be expended all sums disbursed by the district. ((~~The county treasurer of the county in the district embracing only one county; or,~~)) In a district composed of more than one county the county treasurer of the county having the largest population shall be the custodian of the fund, and the county auditor of said county shall keep the record of the receipts and disbursements, and shall draw and the county treasurer shall honor and pay all warrants, which shall be approved before issuance and payment as directed by the board((~~: PROVIDED, That in local health departments wherein a city of over one hundred thousand population is a part of said department, the local board of health may pool the funds available for public health purposes in the office of the city treasurer in a special pooling fund to be established and which shall be expended as set forth above~~)).

Each county((~~, city or town~~)) which is included in the district shall contribute such sums towards the expense for maintaining and operating the district as shall be agreed upon between it and the local board of health in accordance with guidelines established by the state board of health ((~~after consultation with the Washington state association of counties and the association of Washington cities. In the event that no agreement can be reached between the district board of health and the county, city or town, the matter shall be resolved by a board of arbitrators to consist of a representative of the district board of health, a representative from the county, city or town involved, and a third representative to be appointed by the two representatives, but if they are unable to agree, a representative shall be appointed by a judge in the county in which the city or town is located. The determination of the proportionate share to be paid by a county, city or town shall be binding on all parties. Payments into the fund of the district may be made by the county or city or town members during the first year of membership in said district from any funds of the respective county, city or town as would otherwise be available for expenditures for health facilities and services, and thereafter the members shall include items in their respective budgets for payments to finance the health district~~)).

Sec. 247. RCW 70.46.085 and 1967 ex.s. c 51 s 20 are each amended to read as follows:

The expense of providing public health services shall be borne by each county((~~, city or town~~)) within the health district((~~, and the local health officer shall certify the amount agreed upon or as determined pursuant to RCW 70.46.080, and remaining unpaid by each county, city or town to the fiscal or warrant issuing officer of such county, city or town.~~

~~If the expense as certified is not paid by any county, city or town within thirty days after the end of the fiscal year, the local health officer shall certify the amount due to the auditor of the county in which the governmental unit is situated who shall promptly issue his warrant on the county treasurer payable out of the current expense fund of the county, which fund shall be reimbursed by the county auditor out of the money due said governmental unit at the next monthly settlement or settlements of the collection of taxes and shall be transferred to the current expense fund~~)).

Sec. 248. RCW 70.46.090 and 1967 ex.s. c 51 s 21 are each amended to read as follows:

Any county ((~~or any city or town~~)) may withdraw from membership in said health district any time after it has been within the district for a period of two years, but no withdrawal shall be effective except at the end of the calendar year in which the county((~~, city or town~~)) gives at least six months' notice of its intention to withdraw at the end of the calendar year. No withdrawal shall entitle any member to a refund of any moneys paid to the district nor relieve it of any obligations to pay to the district all sums for which it obligated itself due and owing by it to the district for the year at the end of which the withdrawal is to be effective: PROVIDED, That any county((~~, city or town~~)) which withdraws from membership in said health district shall immediately establish a health department or provide health services which shall meet the standards for health services promulgated by the state board of health: PROVIDED FURTHER, That no local health department shall be deemed to provide adequate public health services unless there is at least one full time professionally trained and qualified physician as set forth in RCW 70.05.050.

Sec. 249. RCW 70.46.120 and 1963 c 121 s 1 are each amended to read as follows:

In addition to all other powers and duties, health districts shall have the power to charge fees in connection with the issuance or renewal of a license or permit required by law: PROVIDED, That the fees charged shall not exceed the actual cost involved in issuing or renewing the license or permit((~~: PROVIDED FURTHER, That no fees shall be charged pursuant to this section within the corporate limits of any city or town which prior to the enactment of this section charged fees in connection with the issuance or renewal of a license or permit pursuant to city or town ordinance and where said city or town makes a direct contribution to said health district, unless such city or town expressly consents thereto~~)).

Sec. 250. RCW 82.44.110 and 1991 c 199 s 221 are each amended to read as follows:

The county auditor shall regularly, when remitting license fee receipts, pay over and account to the director of licensing for the excise taxes collected under the provisions of this chapter. The director shall forthwith transmit the excise taxes to the state treasurer.

(1) The state treasurer shall deposit the excise taxes collected under RCW 82.44.020(1) as follows:

(a) 1.60 percent into the motor vehicle fund to defray administrative and other expenses incurred by the department in the collection of the excise tax.

(b) 8.15 percent into the Puget Sound capital construction account in the motor vehicle fund.

(c) 4.07 percent into the Puget Sound ferry operations account in the motor vehicle fund.

(d) ((~~8.83~~)) 5.88 percent into the general fund to be distributed under RCW 82.44.155.

(e) 4.75 percent into the municipal sales and use tax equalization account in the general fund created in RCW 82.14.210.

(f) 1.60 percent into the county sales and use tax equalization account in the general fund created in RCW 82.14.200.

(g) 62.6440 percent into the general fund through June 30, 1993, 57.6440 percent into the general fund beginning July 1, 1993, and 66 percent into the general fund beginning January 1, 1994.

(h) 5 percent into the transportation fund created in RCW 82.44.180 beginning July 1, 1993.

(i) 5.9686 percent into the county criminal justice assistance account created in RCW 82.14.310 through December 31, 1993.

(j) 1.1937 percent into the municipal criminal justice assistance account for distribution under RCW 82.14.320 through December 31, 1993.

(k) 1.1937 percent into the municipal criminal justice assistance account for distribution under RCW 82.14.330 through December 31, 1993.

(l) 2.95 percent into the general fund to be distributed by the state treasurer to county health departments to be used exclusively for public health. The state treasurer shall distribute these funds proportionately among the counties based on population as determined by the most recent United States census.

(2) The state treasurer shall deposit the excise taxes collected under RCW 82.44.020(2) into the transportation fund.

(3) The state treasurer shall deposit the excise tax imposed by RCW 82.44.020(3) into the air pollution control account created by RCW 70.94.015.

Sec. 251. RCW 82.44.155 and 1991 c 199 s 223 are each amended to read as follows:

When distributions are made under RCW 82.44.150, the state treasurer shall apportion and distribute the motor vehicle excise taxes deposited into the general fund under RCW 82.44.110((~~(4)~~))(1)(d) to the cities and towns ratably on the basis of population as last determined by the office of financial management. When so apportioned, the amount payable to each such city and town shall be transmitted to the city treasurer thereof, and shall be used by the city or town for the purposes of police and fire protection ((~~and the preservation of the public health~~)) in the city or town, and not otherwise. If it is adjudged that revenue derived from the excise taxes imposed by RCW 82.44.020 (1) and (2) cannot lawfully be apportioned or distributed to cities or towns, all moneys directed by this section to be apportioned and distributed to cities and towns shall be credited and transferred to the state general fund.

Sec. 252. RCW 43.20.030 and 1984 c 287 s 75 are each amended to read as follows:

The state board of health shall be composed of ten members. These shall be the secretary or the secretary's designee and nine other persons to be appointed by the governor, including four persons experienced in matters of health and sanitation, ((~~an elected city official who is a member of a local health board, an~~)) two elected county officials who ((~~is a~~)) are members of a local health board, a local health officer, and two persons representing the consumers of health care. ((~~Before appointing the city official, the governor shall consider any recommendations submitted by the association of Washington cities.~~)) Before appointing the county official, the governor shall consider any recommendations submitted by the Washington state association of counties. Before appointing the local health officer, the governor shall consider any recommendations submitted by the Washington state association of local public health officials. Before appointing one of the two consumer representatives, the governor shall consider any recommendations submitted by the state council on aging. The chairman shall be selected by the governor from among the nine appointed members. The department ((~~of social and health services~~)) shall provide necessary technical staff support to the board. The board may employ an executive director and a confidential secretary, each of whom shall be exempt from the provisions of the state civil service law, chapter 41.06 RCW.

Members of the board shall be compensated in accordance with RCW 43.03.240 and shall be reimbursed for their travel expenses in accordance with RCW 43.03.050 and 43.03.060.

NEW SECTION. **Sec. 253.** RCW 70.08.010, as amended by this act, shall be recodified in chapter 70.05 RCW.

NEW SECTION. **Sec. 254.** The following acts or parts of acts are each repealed:

(1) RCW 70.05.005 and 1989 1st ex.s. c 9 s 243;

(2) RCW 70.05.020 and 1967 ex.s. c 51 s 2;

(3) RCW 70.05.132 and 1984 c 25 s 9 & 1983 1st ex.s. c 39 s 6;

(4) RCW 70.05.145 and 1983 1st ex.s. c 39 s 5;

(5) RCW 70.12.005 and 1989 1st ex.s. c 9 s 245;

(6) RCW 70.46.030 and 1991 c 363 s 141, 1969 ex.s. c 70 s 1, 1967 ex.s. c 51 s 5, & 1945 c 183 s 3;

(7) RCW 70.46.040 and 1967 ex.s. c 51 s 7 & 1945 c 183 s 4; and

1 (8) RCW 70.46.050 and 1967 ex.s. c 51 s 8, 1957 c 100 s 1, & 1945
2 c 183 s 5.

3 NEW SECTION. **Sec. 255.** It is hereby requested that the governing
4 authorities of the association of Washington cities, the Washington
5 state association of counties, and the Washington association of county
6 officials jointly initiate a study and develop consensus
7 recommendations regarding implementation of the provisions of sections
8 231 through 254 of this act. The study and recommendations should at
9 a minimum include consideration of the fiscal impact of these sections
10 on counties, the desirability of maintaining a process whereby city
11 officials can effectively communicate concerns regarding the delivery
12 of public health services to both the counties and the state, the need
13 for larger cities to be able to continue to provide supplemental health
14 care services when needed, and other matters as the three associations
15 agree are of substance in the implementation of sections 231 through
16 254 of this act. The agreed upon recommendations shall be presented to
17 the senate health and human services and house of representatives
18 health care committees prior to December 31, 1993.

19 **F. DATA COLLECTION**

20 **Sec. 256.** RCW 70.170.100 and 1990 c 269 s 12 are each amended to
21 read as follows:
22 (1) To promote the public interest consistent with the purposes of
23 chapter . . ., Laws of 1993 (this act), the department is responsible
24 for the development, implementation, and custody of a state-wide
25 ((hospital)) health care data system, with policy direction and
26 oversight to be provided by the Washington health services commission.
27 As part of the design stage for development of the system, the
28 department shall undertake a needs assessment of the types of, and
29 format for, ((hospital)) health care data needed by consumers,
30 purchasers, health care payers, ((hospitals)) providers, and state
31 government as consistent with the intent of chapter . . ., Laws of 1993
32 (this act) ((chapter)). The department shall identify a set of
33 ((hospital)) health care data elements and report specifications which
34 satisfy these needs. The ((council)) Washington health services
35 commission, created by section 403 of this act, shall review the design
36 of the data system and may ((direct the department to)) establish a

technical advisory committee on health data and shall, if deemed cost-effective and efficient, recommend that the department contract with a private vendor for assistance in the design of the data system or for any part of the work to be performed under this section. The data elements, specifications, and other ((~~design~~)) distinguishing features of this data system shall be made available for public review and comment and shall be published, with comments, as the department's first data plan by ((~~January 1, 1990~~)) July 1, 1994.

(2) Subsequent to the initial development of the data system as published as the department's first data plan, revisions to the data system shall be considered ((~~through the department's development of a biennial data plan, as proposed to,~~)) with the oversight and policy guidance of the Washington health services commission or its technical advisory committee and funded by((~~,~~)) the legislature through the biennial appropriations process with funds appropriated to the health services account. ((~~Costs of data activities outside of these data plans except for special studies shall be funded through legislative appropriations.~~

~~(3)~~)) In designing the state-wide ((~~hospital~~)) health care data system and any data plans, the department shall identify ((~~hospital~~)) health care data elements relating to ((~~both hospital finances~~)) health care costs, the quality of health care services, the outcomes of health care services, and ((~~the~~)) use of ((~~services by patients~~)) health care by consumers. Data elements ((~~relating to hospital finances~~)) shall be reported ((~~by hospitals~~)) as the Washington health services commission directs by reporters in conformance with a uniform ((~~system of~~)) reporting ((~~as specified by the department and shall~~)) system established by the department, which shall be adopted by reporters. "Reporter" means an individual or business entity, other than a hospital, required to be registered with the department of revenue for payment of taxes imposed under chapter 82.04 RCW or Title 48 RCW, that is primarily engaged in furnishing or insuring for medical, surgical, and other health services to persons. In the case of hospitals this includes data elements identifying each hospital's revenues, expenses, contractual allowances, charity care, bad debt, other income, total units of inpatient and outpatient services, and other financial information reasonably necessary to fulfill the purposes of chapter . . ., Laws of 1993 (this ((~~chapter~~)) act), for hospital activities as a whole and, as feasible and appropriate, for specified classes of

hospital purchasers and payers. Data elements relating to use of hospital services by patients shall, at least initially, be the same as those currently compiled by hospitals through inpatient discharge abstracts ((~~and reported to the Washington state hospital commission~~)). The commission and the department shall encourage and permit reporting by electronic transmission or hard copy as is practical and economical to reporters.

((~~(4)~~)) (3) The state-wide ((~~hospital~~)) health care data system shall be uniform in its identification of reporting requirements for ((~~hospitals~~)) reporters across the state to the extent that such uniformity is ((~~necessary~~)) useful to fulfill the purposes of chapter . . ., Laws of 1993 (this ((~~chapter~~)) act). Data reporting requirements may reflect differences ((~~in hospital size; urban or rural location; scope, type, and method of providing service; financial structure; or other pertinent distinguishing factors~~)) that involve pertinent distinguishing features as determined by the Washington health services commission by rule. So far as ((~~possible~~)) is practical, the data system shall be coordinated with any requirements of the trauma care data registry as authorized in RCW 70.168.090, the federal department of health and human services in its administration of the medicare program, ((~~and~~)) the state in its role of gathering public health statistics, or any other payer program of consequence so as to minimize any unduly burdensome reporting requirements imposed on ((~~hospitals~~)) reporters.

((~~(5)~~)) (4) In identifying financial reporting requirements under the state-wide ((~~hospital~~)) health care data system, the department may require both annual reports and condensed quarterly reports from reporters, so as to achieve both accuracy and timeliness in reporting, but shall craft such requirements with due regard of the data reporting burdens of reporters.

((~~(6) In designing the initial state-wide hospital data system as published in the department's first data plan, the department shall review all existing systems of hospital financial and utilization reporting used in this state to determine their usefulness for the purposes of this chapter, including their potential usefulness as revised or simplified.~~

~~(7) Until such time as the state-wide hospital data system and first data plan are developed and implemented and hospitals are able to comply with reporting requirements, the department shall require~~

~~hospitals to continue to submit the hospital financial and patient discharge information previously required to be submitted to the Washington state hospital commission. Upon publication of the first data plan, hospitals shall have a reasonable period of time to comply with any new reporting requirements and, even in the event that new reporting requirements differ greatly from past requirements, shall comply within two years of July 1, 1989.~~

~~(8)~~)) (5) The ((~~hospital~~)) health care data collected ((~~and~~)), maintained, and studied by the department or the Washington health services commission shall only be available for retrieval in original or processed form to public and private requestors and shall be available within a reasonable period of time after the date of request. The cost of retrieving data for state officials and agencies shall be funded through the state general appropriation. The cost of retrieving data for individuals and organizations engaged in research or private use of data or studies shall be funded by a fee schedule developed by the department which reflects the direct cost of retrieving the data or study in the requested form.

(6) All persons subject to chapter . . ., Laws of 1993 (this act) shall comply with departmental or commission requirements established by rule in the acquisition of data.

Sec. 257. RCW 70.170.110 and 1989 1st ex.s. c 9 s 511 are each amended to read as follows:

The department shall provide, or may contract with a private entity to provide, ((~~hospital~~)) analyses and reports or any studies it chooses to conduct consistent with the purposes of chapter . . ., Laws of 1993 (this ((~~chapter~~)) act). Subject to the availability of funds and any policy direction that may be given by the Washington health services commission. ((~~Prior to release, the department shall provide affected hospitals with an opportunity to review and comment on reports which identify individual hospital data with respect to accuracy and completeness, and otherwise shall focus on aggregate reports of hospital performance.~~)) These studies, analyses, or reports shall include:

(1) Consumer guides on purchasing ((~~hospital care services and~~)) or consuming health care and publications providing verifiable and useful aggregate comparative information to ((~~consumers on hospitals and hospital services~~)) the public on health care services, their cost, and

the quality of health care providers who participate in certified health plans;

(2) Reports for use by classes of purchasers, who purchase from certified health plans, health care payers, and providers as specified for content and format in the state-wide data system and data plan; ((and))

(3) Reports on relevant ((hospital)) health care policy ((issues)) including the distribution of hospital charity care obligations among hospitals; absolute and relative rankings of Washington and other states, regions, and the nation with respect to expenses, net revenues, and other key indicators; ((hospital)) provider efficiencies; and the effect of medicare, medicaid, and other public health care programs on rates paid by other purchasers of ((hospital)) health care; and

(4) Any other reports the commission or department deems useful to assist the public or purchasers of certified health plans in understanding the prudent and cost-effective use of certified health plan services.

NEW SECTION. **Sec. 258.** A new section is added to chapter 70.170 RCW to read as follows:

Notwithstanding the provisions of chapter 42.17 RCW, any material contained within the state-wide health care data system or in the files of either the department or the Washington health services commission shall be subject to the following limitations: (1) Records obtained, reviewed by, or on file that contain information concerning medical treatment of individuals shall be exempt from public inspection and copying; and (2) any actuarial formulas, statistics, and assumptions submitted by a certified health plan to the commission or department upon request shall be exempt from public inspection and copying in order to preserve trade secrets or prevent unfair competition.

All persons and any public or private agencies or entities whatsoever subject to this chapter shall comply with any requirements established by rule relating to the acquisition or use of health services data and maintain the confidentiality of any information which may, in any manner, identify individual persons.

NEW SECTION. **Sec. 259.** A new section is added to chapter 70.170 RCW to read as follows:

1 The Washington health services commission shall have access to all
2 health data presently available to the secretary of health. To the
3 extent possible, the commission shall use existing data systems and
4 coordinate among existing agencies. The department of health shall be
5 the designated depository agency for all health data collected pursuant
6 to chapter . . ., Laws of 1993 (this act). The following data sources
7 shall be developed or made available:
8 (1) The commission shall coordinate with the secretary of health to
9 utilize data collected by the state center for health statistics,
10 including hospital charity care and related data, rural health data,
11 epidemiological data, ethnicity data, social and economic status data,
12 and other data relevant to the commission's responsibilities.
13 (2) The commission, in coordination with the department of health
14 and the health science programs of the state universities shall develop
15 procedures to analyze clinical and other health services outcome data,
16 and conduct other research necessary for the specific purpose of
17 assisting in the design of the uniform benefit package under chapter
18 . . ., Laws of 1993 (this act).
19 (3) The commission shall establish cost data sources and shall
20 require each certified health plan to provide the commission and the
21 department of health with enrollee care and cost information, to
22 include, but not be limited to: (a) Enrollee identifier, including
23 date of birth, sex, and ethnicity; (b) provider identifier; (c)
24 diagnosis; (d) health care services or procedures provided; (e)
25 provider charges, if any; and (f) amount paid. The department shall
26 establish by rule confidentiality standards to safeguard the
27 information from inappropriate use or release.
28 (4) The commission shall coordinate with the area Indian health
29 service, reservation Indian health service units, tribal clinics, and
30 any urban Indian health service organizations the design, development,
31 implementation, and maintenance of an American Indian-specific health
32 data, statistics information system. The commission rules regarding
33 the confidentiality to safeguard the information from inappropriate use
34 or release shall apply.

35 NEW SECTION. **Sec. 260.** A new section is added to chapter 70.170
36 RCW to read as follows:
37 (1) The department is responsible for the implementation and
38 custody of a state-wide personal health services data and information

system. The data elements, specifications, and other design features of this data system shall be consistent with criteria adopted by the Washington health services commission. The department shall provide the commission with reasonable assistance in the development of these criteria, and shall provide the commission with periodic progress reports related to the implementation of the system or systems related to those criteria.

(2) The department shall coordinate the development and implementation of the personal health services data and information system with related private activities and with the implementation activities of the data sources identified by the commission. Data shall include: (a) Enrollee identifier, including date of birth, sex, and ethnicity; (b) provider identifier; (c) diagnosis; (d) health services or procedures provided; (e) provider charges, if any; and (f) amount paid. The commission shall establish by rule, confidentiality standards to safeguard the information from inappropriate use or release. The department shall assist the commission in establishing reasonable time frames for the completion of the system development and system implementation.

NEW SECTION. **Sec. 261.** The commission shall determine, by January 1, 1995, the necessity, if any, of reporting requirements by the following health care entities: Health care providers, health care facilities, insuring entities, and certified health plans. The reporting requirements, if any, shall be for the purposes of determining whether the health care system is operating as efficiently as possible. Information reported pursuant to this section shall be made available to interested parties upon request. The commission shall report its findings to the legislature by January 1, 1995.

NEW SECTION. **Sec. 262.** A new section is added to chapter 70.170 RCW to read as follows:

The department shall establish in conjunction with the area Indian health services system and providers an advisory group comprised of Indian and non-Indian health care facilities and providers to formulate an American Indian health care delivery element for the health services improvement plan. The element shall include:

(1) Recommendations to providers and facilities methods for coordinating and joint venturing with the Indian health services for service delivery;

(2) Methods to improve American Indian-specific health programming; and

(3) Creation of co-funding recommendations and opportunities for the unmet health care needs of American Indians.

G. DISCLOSURE OF HOSPITAL, NURSING HOME, AND PHARMACY CHARGES

NEW SECTION. **Sec. 263.** A new section is added to chapter 70.41 RCW to read as follows:

(1) The legislature finds that the spiraling costs of health care continue to surmount efforts to contain them, increasing at approximately twice the inflationary rate. The causes of this phenomenon are complex. By making physicians and other health care providers with hospital admitting privileges more aware of the cost consequences of health care services for consumers, these providers may be inclined to exercise more restraint in providing only the most relevant and cost-beneficial hospital services, with a potential for reducing the utilization of those services. The requirement of the hospital to inform physicians and other health care providers of the charges of the health care services that they order may have a positive effect on containing health costs. Further, the option of the physician or other health care provider to inform the patient of these charges may strengthen the necessary dialogue in the provider-patient relationship that tends to be diminished by intervening third-party payers.

(2) The chief executive officer of a hospital licensed under this chapter and the superintendent of a state hospital shall establish and maintain a procedure for disclosing to physicians and other health care providers with admitting privileges the charges of all health care services ordered for their patients. Copies of hospital charges shall be made available to any physician and/or other health care provider ordering care in hospital inpatient/outpatient services. The physician and/or other health care provider may inform the patient of these charges and may specifically review them. Hospitals are also directed to study methods for making daily charges available to prescribing physicians through the use of interactive software and/or computerized

information thereby allowing physicians and other health care providers to review not only the costs of present and past services but also future contemplated costs for additional diagnostic studies and therapeutic medications.

NEW SECTION. **Sec. 264.** A new section is added to chapter 18.68 RCW to read as follows:

The legislature finds that the spiraling costs of health care continue to surmount efforts to contain them, increasing at approximately twice the inflationary rate. One of the fastest growing segments of the health care expenditure involves prescription medications. By making physicians and other health care providers with prescriptive authority more aware of the cost consequences of health care treatments for consumers, these providers may be inclined to exercise more restraint in providing only the most relevant and cost-beneficial drug and medication treatments. The requirement of the pharmacy to inform physicians and other health care providers of the charges of prescription drugs and medications that they order may have a positive effect on containing health costs. Further, the option of the physician or other health care provider to inform the patient of these charges may strengthen the necessary dialogue in the provider-patient relationship that tends to be diminished by intervening third-party payers.

NEW SECTION. **Sec. 265.** A new section is added to chapter 18.68 RCW to read as follows:

The registered or licensed pharmacist of this chapter shall establish and maintain a procedure for disclosing to physicians and other health care providers with prescriptive authority information detailed by prescriber, of the cost and dispensation of all prescriptive medications prescribed by him or her for his or her patients on request. These charges should be made available on at least a quarterly basis for all requested patients and should include medication, dosage, number dispensed, and the cost of the prescription. Pharmacies may provide this information in a summary form for each prescribing physician for all patients rather than as individually itemized reports. All efforts should be made to utilize the existing computerized records and software to provide this information in the least costly format.

1 <u>NEW SECTION.</u> **Sec. 266.** A new section is added to chapter 18.51
2 RCW to read as follows:
3 (1) The legislature finds that the spiraling costs of nursing home
4 care continue to surmount efforts to contain them, increasing at
5 approximately twice the inflationary rate. The causes of this
6 phenomenon are complex. By making nursing home facilities and care
7 providers more aware of the cost consequences of care services for
8 consumers, these providers may be inclined to exercise more restraint
9 in providing only the most relevant and cost-beneficial services and
10 care, with a potential for reducing the utilization of those services.
11 The requirement of the nursing home to inform physicians, consumers,
12 and other care providers of the charges of the services that they order
13 may have a positive effect on containing health costs.
14 (2) All nursing home administrators in facilities licensed under
15 this chapter shall be required to develop and maintain a written
16 procedure for disclosing patient charges to attending physicians with
17 admitting privileges. The nursing home administrator shall have the
18 capability to provide an itemized list of the charges for all health
19 care services that may be ordered by a physician. The information
20 shall be made available on request of consumers, or the physicians or
21 other appropriate health care providers responsible for prescribing
22 care.

23 <u>NEW SECTION.</u> **Sec. 267.** The department of health shall report to
24 the legislature by December 31, 1994, with recommendations on any
25 necessary revisions to sections 263 through 266 of this act, including
26 their continued necessity and the appropriateness of their repeal.

27 **H. HEALTH PROFESSIONAL SHORTAGES**

28 <u>NEW SECTION.</u> **Sec. 268.** LEGISLATIVE INTENT. The legislature finds
29 that the successful implementation of health care reform will depend on
30 a sufficient supply of primary health care providers throughout the
31 state. Many rural and medically underserved urban areas lack primary
32 health care providers and because of this, basic health care services
33 are limited or unavailable to populations living in these areas. The
34 legislature has in recent years initiated new programs to address these
35 provider shortages but funding has been insufficient and additional
36 specific provider shortages remain.

Sec. 269. RCW 28B.125.010 and 1991 c 332 s 5 are each amended to read as follows:

(1) The higher education coordinating board, the state board for community ((~~college education~~)) and technical colleges, the superintendent of public instruction, the state department of health, the Washington health services commission, and the state department of social and health services, to be known for the purposes of this section as the committee, shall establish a state-wide health personnel resource plan. The governor shall appoint a lead agency from one of the agencies on the committee.

In preparing the state-wide plan the committee shall consult with the training and education institutions affected by this chapter, health care providers, employers of health care providers, insurers, consumers of health care, and other appropriate entities.

Should a successor agency or agencies be authorized or created by the legislature with planning, coordination, or administrative authority over vocational-technical schools, community colleges, or four-year higher education institutions, the governor shall grant membership on the committee to such agency or agencies and remove the member or members it replaces.

The committee shall appoint subcommittees for the purpose of assisting in the development of the institutional plans required under this chapter. Such subcommittees shall at least include those committee members that have statutory responsibility for planning, coordination, or administration of the training and education institutions for which the institutional plans are being developed. In preparing the institutional plans for four-year institutes of higher education, the subcommittee shall be composed of at least the higher education coordinating board and the state's four-year higher education institutions. The appointment of subcommittees to develop portions of the state-wide plan shall not relinquish the committee's responsibility for assuring overall coordination, integration, and consistency of the state-wide plan.

In establishing and implementing the state-wide health personnel resource plan the committee shall, to the extent possible, utilize existing data and information, personnel, equipment, and facilities and shall minimize travel and take such other steps necessary to reduce the administrative costs associated with the preparation and implementation of the plan.

(2) The state-wide health resource plan shall include at least the following:

(a)(i) Identification of the type, number, and location of the health care professional work force necessary to meet health care needs of the state.

(ii) A description and analysis of the composition and numbers of the potential work force available for meeting health care service needs of the population to be used for recruitment purposes. This should include a description of the data, methodology, and process used to make such determinations.

(b) A centralized inventory of the numbers of student applications to higher education and vocational-technical training and education programs, yearly enrollments, yearly degrees awarded, and numbers on waiting lists for all the state's publicly funded health care training and education programs. The committee shall request similar information for incorporation into the inventory from private higher education and vocational-technical training and education programs.

(c) A description of state-wide and local specialized provider training needs to meet the health care needs of target populations and a plan to meet such needs in a cost-effective and accessible manner.

(d) A description of how innovative, cost-effective technologies such as telecommunications can and will be used to provide higher education, vocational-technical, continued competency, and skill maintenance and enhancement education and training to placebound students who need flexible programs and who are unable to attend institutions for training.

(e) A strategy for assuring higher education and vocational-technical educational and training programming is sensitive to the changing work force such as reentry workers, women, minorities, and the disabled.

(f) Strategies for promoting an increase in the use of persons of color in the health professions including adequate resources to train and utilize persons of color in the full spectrum of health professions, to include physicians, licensed physicians who are foreign medical graduates, nurses, administrators, planners, education, technicians, outreach workers, and dentists.

(g) A strategy that includes the incorporation of federal assistance programs for health career development with an emphasis on the national Indian health service programs targeting the American

Indian population and other federal and state education and training assistance programs for the economically disadvantaged, physically challenged, and persons of color in all health professions.

((~~(f)~~)) (g) A strategy and coordinated state-wide policy developed by the subcommittees authorized in subsection (1) of this section for increasing the number of graduates intending to serve in shortage areas after graduation, including such strategies as the establishment of preferential admissions and designated enrollment slots.

((~~(g)~~)) (h) Guidelines and policies developed by the subcommittees authorized in subsection (1) of this section for allowing academic credit for on-the-job experience such as internships, volunteer experience, apprenticeships, and community service programs.

((~~(h)~~)) (i) A strategy developed by the subcommittees authorized in subsection (1) of this section for making required internships and residency programs available that are geographically accessible and sufficiently diverse to meet both general and specialized training needs as identified in the plan when such programs are required.

((~~(i)~~)) (j) A description of the need for multiskilled health care professionals and an implementation plan to restructure educational and training programming to meet these needs.

((~~(j)~~)) (k) An analysis of the types and estimated numbers of health care personnel that will need to be recruited from out-of-state to meet the health professional needs not met by in-state trained personnel.

((~~(k)~~)) (l) An analysis of the need for educational articulation within the various health care disciplines and a plan for addressing the need.

((~~(l)~~)) (m) An analysis of the training needs of those members of the long-term care profession that are not regulated and that have no formal training requirements. Programs to meet these needs should be developed in a cost-effective and a state-wide accessible manner that provide for the basic training needs of these individuals.

((~~(m)~~)) (n) A designation of the professions and geographic locations in which loan repayment and scholarships should be available based upon objective data-based forecasts of health professional shortages. A description of the criteria used to select professions and geographic locations shall be included. Designations of professions and geographic locations may be amended by the department

of health when circumstances warrant as provided for in RCW 28B.115.070.

((~~(n)~~)) (o) A description of needed changes in regulatory laws governing the credentialing of health professionals.

((~~(o)~~)) (p) A description of linguistic and cultural training needs of foreign-trained health care professionals to assure safe and effective practice of their health care profession.

((~~(p)~~)) (q) A plan to implement the recommendations of the state-wide nursing plan authorized by RCW 74.39.040.

((~~(q)~~)) (r) A description of criteria and standards that institutional plans provided for in this section must address in order to meet the requirements of the state-wide health personnel resource plan, including funding requirements to implement the plans. The committee shall also when practical identify specific outcome measures to measure progress in meeting the requirements of this plan. The criteria and standards shall be established in a manner as to provide flexibility to the institutions in meeting state-wide plan requirements. The committee shall establish required submission dates for the institutional plans that permit inclusion of funding requests into the institutions budget requests to the state.

((~~(r)~~)) (s) A description of how the higher education coordinating board, state board for community ((~~college education~~)) and technical colleges, superintendent of public instruction, department of health, and department of social and health services coordinated in the creation and implementation of the state plan including the areas of responsibility each agency shall assume. The plan should also include a description of the steps taken to assure participation by the groups that are to be consulted with.

((~~(s)~~)) (t) A description of the estimated fiscal requirements for implementation of the state-wide health resource plan that include a description of cost saving activities that reduce potential costs by avoiding administrative duplication, coordinating programming activities, and other such actions to control costs.

(3) The committee may call upon other agencies of the state to provide available information to assist the committee in meeting the responsibilities under this chapter. This information shall be supplied as promptly as circumstances permit.

(4) State agencies involved in the development and implementation of the plan shall to the extent possible utilize existing personnel and

financial resources in the development and implementation of the state-wide health personnel resource plan.

(5) The state-wide health personnel resource plan shall be submitted to the governor by July 1, 1992, and updated by July 1 of each even-numbered year. The governor, no later than December 1 of that year, shall approve, approve with modifications, or disapprove the state-wide health resource plan.

(6) The approved state-wide health resource plan shall be submitted to the senate and house of representatives committees on health care, higher education, and ways and means or appropriations by December 1 of each even-numbered year.

(7) Implementation of the state-wide plan shall begin by July 1, 1993.

(8) Notwithstanding subsections (5) and (7) of this section, the committee shall prepare and submit to the higher education coordinating board by June 1, 1992, the analysis necessary for the initial implementation of the health professional loan repayment and scholarship program created in chapter 28B.115 RCW.

(9) Each publicly funded two-year and four-year institute of higher education authorized under Title 28B RCW and vocational-technical institution authorized under Title 28A RCW that offers health training and education programs shall biennially prepare and submit an institutional plan to the committee. The institutional plan shall identify specific programming and activities of the institution that meet the requirements of the state-wide health professional resource plan.

The committee shall review and assess whether the institutional plans meet the requirements of the state-wide health personnel resource plan and shall prepare a report with its determination. The report shall become part of the institutional plan and shall be submitted to the governor and the legislature.

The institutional plan shall be included with the institution's biennial budget submission. The institution's budget shall identify proposed spending to meet the requirements of the institutional plan. Each vocational-technical institution, college, or university shall be responsible for implementing its institutional plan.

Sec. 270. RCW 28B.115.080 and 1991 c 332 s 21 are each amended to read as follows:

1 After June 1, 1992, the board, in consultation with the department
2 and the department of social and health services, shall:
3 (1) Establish the annual award amount for each credentialed health
4 care profession which shall be based upon an assessment of reasonable
5 annual eligible expenses involved in training and education for each
6 credentialed health care profession. The annual award amount may be
7 established at a level less than annual eligible expenses. The annual
8 award amount shall ((~~not be more than fifteen thousand dollars per~~
9 ~~year~~)) be established by the board for each eligible health profession.
10 The awards shall not be paid for more than a maximum of five years per
11 individual;
12 (2) Determine any scholarship awards for prospective physicians in
13 such a manner to require the recipients declare an interest in serving
14 in rural areas of the state of Washington. Preference for scholarships
15 shall be given to students who reside in a rural physician shortage
16 area or a nonshortage rural area of the state prior to admission to the
17 eligible education and training program in medicine. Highest
18 preference shall be given to students seeking admission who are
19 recommended by sponsoring communities and who declare the intent of
20 serving as a physician in a rural area. The board may require the
21 sponsoring community located in a nonshortage rural area to financially
22 contribute to the eligible expenses of a medical student if the student
23 will serve in the nonshortage rural area;
24 (3) Establish the required service obligation for each credentialed
25 health care profession, which shall be no less than three years or no
26 more than five years. The required service obligation may be based
27 upon the amount of the scholarship or loan repayment award such that
28 higher awards involve longer service obligations on behalf of the
29 participant;
30 (4) Determine eligible education and training programs for purposes
31 of the scholarship portion of the program;
32 (5) Honor loan repayment and scholarship contract terms negotiated
33 between the board and participants prior to May 21, 1991, concerning
34 loan repayment and scholarship award amounts and service obligations
35 authorized under chapter ((~~18.150~~)) 28B.115, 28B.104, or 70.180 RCW.

36 NEW SECTION. **Sec. 271.** A new section is added to chapter 43.70
37 RCW to read as follows:

MULTICULTURAL HEALTH CARE TECHNICAL ASSISTANCE PROGRAM. (1) Consistent with funds appropriated specifically for this purpose, the department shall provide matching grants to support a community-based multicultural health care technical assistance program. Its purpose shall be to promote technical assistance to community and migrant health clinics and other appropriate health care providers who serve principally the underserved and persons of color.

The technical assistance provided shall include, but is not limited to: (a) Collaborative research and data analysis on health care outcomes that disproportionately affect persons of color; (b) design and development of model health education and promotion strategies aimed at modifying unhealthy health behaviors or enhancing the use of the health care delivery system by persons of color; (c) provision of technical information and assistance on program planning and financial management; (d) administration, public policy development, and analysis in health care issues affecting people of color; and (e) enhancement and promotion of health care career opportunities for persons of color.

(2) Consistent with appropriate funds, the programs shall be available on a state-wide basis.

Sec. 272. RCW 70.185.030 and 1991 c 332 s 9 are each amended to read as follows:

COMMUNITY-BASED RECRUITMENT AND RETENTION--UNDERSERVED URBAN AREAS. (1) The department ((~~shall~~)) may, subject to funding, establish ((~~up to three~~)) community-based recruitment and retention project sites to provide financial and technical assistance to participating communities. The goal of the project is to help assure the availability of health care providers in rural and underserved urban areas of Washington state.

(2) Administrative costs necessary to implement this project shall be kept at a minimum to insure the maximum availability of funds for participants.

(3) The secretary may contract with third parties for services necessary to carry out activities to implement this chapter where this will promote economy, avoid duplication of effort, and make the best use of available expertise.

(4) The secretary may apply for, receive, and accept gifts and other payments, including property and service, from any governmental or other public or private entity or person, and may make arrangements

1 as to the use of these receipts, including the undertaking of special
2 studies and other projects related to the delivery of health care in
3 rural areas.
4 (5) In designing and implementing the project the secretary shall
5 coordinate the project with the Washington rural health system project
6 as authorized under chapter 70.175 RCW to consolidate administrative
7 duties and reduce costs.

8 **Sec. 273.** RCW 43.70.460 and 1992 c 113 s 2 are each amended to
9 read as follows:
10 RETIRED PRIMARY CARE PROVIDERS--MALPRACTICE INSURANCE. (1) The
11 department may establish a program to purchase and maintain liability
12 malpractice insurance for retired ((~~physicians~~)) primary care providers
13 who provide primary health care services at community clinics. The
14 following conditions apply to the program:
15 (a) Primary health care services shall be provided at community
16 clinics that are public or private tax-exempt corporations;
17 (b) Primary health care services provided at the clinics shall be
18 offered to low-income patients based on their ability to pay;
19 (c) Retired ((~~physicians~~)) primary care providers providing health
20 care services shall not receive compensation for their services; and
21 (d) The department shall contract only with a liability insurer
22 authorized to offer liability malpractice insurance in the state.
23 (2) This section and RCW 43.70.470 shall not be interpreted to
24 require a liability insurer to provide coverage to a ((~~physician~~))
25 primary care provider should the insurer determine that coverage should
26 not be offered to a physician because of past claims experience or for
27 other appropriate reasons.
28 (3) The state and its employees who operate the program shall be
29 immune from any civil or criminal action involving claims against
30 clinics or physicians that provided health care services under this
31 section and RCW 43.70.470. This protection of immunity shall not
32 extend to any clinic or ((~~physician~~)) primary care provider
33 participating in the program.
34 (4) The department may monitor the claims experience of retired
35 physicians covered by liability insurers contracting with the
36 department.

(5) The department may provide liability insurance under chapter 113, Laws of 1992 only to the extent funds are provided for this purpose by the legislature.

Sec. 274. RCW 43.70.470 and 1992 c 113 s 3 are each amended to read as follows:

RETIRED PRIMARY CARE PROVIDERS--CONDITIONS. The department may establish by rule the conditions of participation in the liability insurance program by retired ((~~physicians~~)) primary care providers at clinics utilizing retired physicians for the purposes of this section and RCW 43.70.460. These conditions shall include, but not be limited to, the following:

(1) The participating ((~~physician~~)) primary care provider associated with the clinic shall hold a valid license to practice ((~~medicine and surgery~~)) as a physician under chapter 18.71 or 18.57 RCW, a naturopath under chapter 18.36A RCW, a physician assistant under chapter 18.71A or 18.57A RCW, or an advanced registered nurse practitioner under chapter 18.88 RCW in this state and otherwise be in conformity with current requirements for licensure as a retired ((~~physician~~)) primary care health care provider, including continuing education requirements;

(2) The participating ((~~physician~~)) primary care health care provider shall limit the scope of practice in the clinic to primary care. Primary care shall be limited to noninvasive procedures and shall not include obstetrical care, or any specialized care and treatment. Noninvasive procedures include injections, suturing of minor lacerations, and incisions of boils or superficial abscesses;

(3) The provision of liability insurance coverage shall not extend to acts outside the scope of rendering medical services pursuant to this section and RCW 43.70.460;

(4) The participating ((~~physician~~)) primary care health care provider shall limit the provision of health care services to primarily low-income persons provided that clinics may, but are not required to, provide means tests for eligibility as a condition for obtaining health care services;

(5) The participating ((~~physician~~)) primary care health care provider shall not accept compensation for providing health care services from patients served pursuant to this section and RCW 43.70.460, nor from clinics serving these patients. "Compensation"

1 shall mean any remuneration of value to the participating ((~~physician~~))
2 primary care health care provider for services provided by the
3 ((~~physician~~)) primary care health care provider, but shall not be
4 construed to include any nominal copayments charged by the clinic, nor
5 reimbursement of related expenses of a participating ((~~physician~~))
6 primary care health care provider authorized by the clinic in advance
7 of being incurred; and
8 (6) The use of mediation or arbitration for resolving questions of
9 potential liability may be used, however any mediation or arbitration
10 agreement format shall be expressed in terms clear enough for a person
11 with a sixth grade level of education to understand, and on a form no
12 longer than one page in length.

13 NEW SECTION. **Sec. 275.** MEDICAL SCHOOL GRADUATES SERVING IN RURAL
14 AND MEDICALLY UNDERSERVED AREAS OF THE STATE--LEGISLATIVE INTENT. The
15 legislature finds that the shortage of primary care physicians
16 practicing in rural and medically underserved areas of the state has
17 created a severe public health and safety problem. If unaddressed,
18 this problem is expected to worsen with health care reform since an
19 increased demand for primary care services will only contribute further
20 to these shortages.
21 The legislature further finds that the medical training program at
22 the University of Washington is an important and well respected
23 resource to the people of this state in the training of primary care
24 physicians. Currently, only a small proportion of medical school
25 graduates are Washington residents who serve as primary care
26 practitioners in certain parts of this state.

27 NEW SECTION. **Sec. 276.** MEDICAL SCHOOL PRIMARY CARE PHYSICIAN
28 SHORTAGE PLAN DEVELOPMENT. (1) The University of Washington shall
29 prepare a primary care shortage plan that accomplishes the following:
30 (a) Identifies specific activities that the school of medicine
31 shall pursue to increase the number of Washington residents serving as
32 primary care physicians in rural and medically underserved areas of the
33 state, including establishing a goal that assures that no less than
34 forty-five percent of medical school graduates who are Washington state
35 residents at the time of matriculation will enter into primary care
36 residencies in Washington state by the year 2000;

(b) Assures that the school of medicine shall establish among its highest training priorities the distribution of its primary care physician graduates from the school and associated postgraduate residency programs into rural and medically underserved areas;

(c) Establishes the goal of assuring that the annual number of graduates from the family practice residency network entering rural or medically underserved practice shall be increased by forty percent over a baseline period from 1985 through 1990 by 1995;

(d) Establishes a further goal to make operational at least two additional family practice residency programs within Washington state in geographic areas identified by the plan as underserved in family practice by 1997. The geographic areas identified by the plan as being underserved by family practice physicians shall be consistent with any such similar designations as may be made in the health personnel research plan as authorized under chapter 28B.125 RCW;

(e) Establishes, with the cooperation of existing community and migrant health clinics in rural or medically underserved areas of the state, three family practice residency training tracks. Furthermore, the primary care shortage plan shall provide that one of these training tracks shall be a joint American osteopathic association and American medical association approved training site coordinated with an accredited college of osteopathic medicine with extensive experience in training primary care physicians for the western United States. Such a proposed joint accredited training track will have at least fifty percent of its residency positions in osteopathic medicine; and

(f) Implements the plan, with the exception of the expansion of the family practice residency network, within current biennial appropriations for the University of Washington school of medicine.

(2) The plan shall be submitted to the appropriate committees of the legislature no later than December 1, 1993.

I. SHORT-TERM HEALTH INSURANCE REFORM

NEW SECTION. **Sec. 277.** The legislature intends that, during the transition to a fully reformed health services system, certain health insurance practices be modified to increase access to health insurance coverage for some individuals and groups. The legislature recognizes that health insurance reform will not remedy the significant lack of access to coverage in Washington state without the implementation of

strong cost control measures. The authority granted to the commissioner in chapter . . ., Laws of 1993 (this act) is in addition to any authority the commissioner currently has under Title 48 RCW to regulate insurers, health care service contractors, and health maintenance organizations.

NEW SECTION. **Sec. 278.** A new section is added to chapter 48.18 RCW to read as follows:

Every insurer upon canceling, denying, or refusing to renew any disability policy, shall, upon written request, directly notify in writing the applicant or insured, as the case may be, of the reasons for the action by the insurer and to any person covered under a group contract. Any benefits, terms, rates, or conditions of such a contract that are restricted, excluded, modified, increased, or reduced shall, upon written request, be set forth in writing and supplied to the insured and to any person covered under a group contract. The written communications required by this section shall be phrased in simple language that is readily understandable to a person of average intelligence, education, and reading ability.

Sec. 279. RCW 48.21.200 and 1983 c 202 s 16 and 1983 c 106 s 24 are each reenacted and amended to read as follows:

(1) No individual or group disability insurance policy, health care service contract, or health maintenance agreement which provides benefits for hospital, medical, or surgical expenses shall be delivered or issued for delivery in this state ((~~after September 8, 1975~~)) which contains any provision whereby the insurer, contractor, or health maintenance organization may reduce or refuse to pay such benefits otherwise payable thereunder solely on account of the existence of similar benefits provided under any ((~~individual~~)) disability insurance policy, ((~~or under any individual~~)) health care service contract, or health maintenance agreement.

(2) No individual or group disability insurance policy, health care service contract, or health maintenance agreement providing hospital, medical or surgical expense benefits and which contains a provision for the reduction of benefits otherwise payable or available thereunder on the basis of other existing coverages, shall provide that such reduction will operate to reduce total benefits payable below an amount

1 equal to one hundred percent of total allowable expenses <u>exclusive of</u>
2 <u>copayments, deductibles, and other similar cost-sharing arrangements</u>.
3 <u>(3)</u> The commissioner shall by rule establish guidelines for the
4 application of this section, including:
5 (a) The procedures by which persons ((~~insured~~)) <u>covered</u> under such
6 policies<u>, contracts, and agreements</u> are to be made aware of the
7 existence of such a provision;
8 (b) <u>T</u>he benefits which may be subject to such a provision;
9 (c) <u>T</u>he effect of such a provision on the benefits provided;
10 (d) <u>E</u>stablishment of the order of benefit determination; ((~~and~~))
11 (e) <u>Exceptions necessary to maintain the integrity of policies,</u>
12 <u>contracts, and agreements that may require the use of particular health</u>
13 <u>care facilities or providers; and</u>
14 <u>(f) R</u>easonable claim administration procedures to expedite claim
15 payments <u>and prevent duplication of payments or benefits</u> under such a
16 provision((~~: PROVIDED, HOWEVER, That any group disability insurance~~
17 ~~policy which is issued as part of an employee insurance benefit program~~
18 ~~authorized by RCW 41.05.025(3) may exclude all or part of any~~
19 ~~deductible amounts from the definition of total allowable expenses for~~
20 ~~purposes of coordination of benefits within the plan and between such~~
21 ~~plan and other applicable group coverages: AND PROVIDED FURTHER, That~~
22 ~~any group disability insurance policy providing coverage for persons in~~
23 ~~this state may exclude all or part of any deductible amounts required~~
24 ~~by a group disability insurance policy from the definition of total~~
25 ~~allowable expenses for purposes of coordination of benefits between~~
26 ~~such policy and a group disability insurance policy issued as part of~~
27 ~~an employee insurance benefit program authorized by RCW 41.05.025(3).~~
28 ~~(3) The provisions of this section shall apply to health care~~
29 ~~service contractor contracts and health maintenance organization~~
30 ~~agreements~~)).

31 <u>NEW SECTION.</u> **Sec. 280.** A new section is added to chapter 48.20
32 RCW to read as follows:
33 (1) After January 1, 1994, every disability insurer issuing
34 coverage against loss arising from medical, surgical, hospital, or
35 emergency care coverage shall waive any preexisting condition exclusion
36 or limitation for persons who had similar coverage under a different
37 policy, health care service contract, or health maintenance agreement
38 in the three-month period immediately preceding the effective date of

coverage under the new policy to the extent that such person has satisfied a waiting period under such preceding policy, contract, or agreement; however, if the person satisfied a twelve-month waiting period under such preceding policy, contract, or agreement, the insurer shall waive any preexisting condition exclusion or limitation. The insurer need not waive a preexisting condition exclusion or limitation under the new policy for coverage not provided under such preceding policy, contract, or agreement.

(2) The commissioner may adopt rules establishing guidelines for determining when coverage is similar under new and preceding policies, contracts, and agreements and for determining when a preexisting condition waiting period has been satisfied.

(3) The commissioner in consultation with insurers, health care service contractors, and health maintenance organizations shall study the effect of preexisting condition exclusions and limitations on the cost and availability of health care coverage and shall adopt rules restricting the use of such conditions and limitations by January 1, 1994. No insurer, health care service contractor, or health maintenance organization may deny, exclude, or limit coverage for preexisting conditions for a period longer than that provided for in such rules after July 1, 1994.

NEW SECTION. **Sec. 281.** A new section is added to chapter 48.21 RCW to read as follows:

(1) After January 1, 1994, every disability insurer issuing coverage against loss arising from medical, surgical, hospital, or emergency care coverage shall waive any preexisting condition exclusion or limitation for persons who had similar coverage under a different policy, health care service contract, or health maintenance agreement in the three-month period immediately preceding the effective date of coverage under the new policy to the extent that such person has satisfied a waiting period under such preceding policy, contract, or agreement; however, if the person satisfied a twelve-month waiting period under such preceding policy, contract, or agreement, the insurer shall waive any preexisting condition exclusion or limitation. The insurer need not waive a preexisting condition exclusion or limitation under the new policy for coverage not provided under such preceding policy, contract, or agreement.

1 (2) The commissioner may adopt rules establishing guidelines for
2 determining when coverage is similar under new and preceding policies,
3 contracts, and agreements and for determining when a preexisting
4 condition waiting period has been satisfied.
5 (3) The commissioner in consultation with insurers, health care
6 service contractors, and health maintenance organizations shall study
7 the effect of preexisting condition exclusions and limitations on the
8 cost and availability of health care coverage and shall adopt rules
9 restricting the use of such conditions and limitations by January 1,
10 1994. No insurer, health care service contractor, or health
11 maintenance organization may deny, exclude, or limit coverage for
12 preexisting conditions for a period longer than that provided for in
13 such rules after July 1, 1994.

14 <u>NEW SECTION.</u> **Sec. 282.** A new section is added to chapter 48.44
15 RCW to read as follows:
16 (1) After January 1, 1994, every health care service contractor,
17 except limited health care service contractors as defined under RCW
18 48.44.035, shall waive any preexisting condition exclusion or
19 limitation for persons who had similar coverage under a different
20 policy, health care service contract, or health maintenance agreement
21 in the three-month period immediately preceding the effective date of
22 coverage under the new contract to the extent that such person has
23 satisfied a waiting period under such preceding policy, contract, or
24 agreement; however, if the person satisfied a twelve-month waiting
25 period under such preceding policy, contract, or agreement, the insurer
26 shall waive any preexisting condition exclusion or limitation. The
27 insurer need not waive a preexisting condition exclusion or limitation
28 under the new policy for coverage not provided under such preceding
29 policy, contract, or agreement.
30 (2) The commissioner may adopt rules establishing guidelines for
31 determining when coverage is similar under new and preceding policies,
32 contracts, and agreements and for determining when a preexisting
33 condition waiting period has been satisfied.
34 (3) The commissioner in consultation with insurers, health care
35 service contractors, and health maintenance organizations shall study
36 the effect of preexisting condition exclusions and limitations on the
37 cost and availability of health care coverage and shall adopt rules
38 restricting the use of such conditions and limitations by January 1,

1994. No insurer, health care service contractor, or health maintenance organization may deny, exclude, or limit coverage for preexisting conditions for a period longer than that provided for in such rules after July 1, 1994.

NEW SECTION. **Sec. 283.** A new section is added to chapter 48.46 RCW to read as follows:

(1) After January 1, 1994, every health maintenance organization shall waive any preexisting condition exclusion or limitation for persons who had similar coverage under a different policy, health care service contract, or health maintenance agreement in the three-month period immediately preceding the effective date of coverage under the new agreement to the extent that such person has satisfied a waiting period under such preceding policy, contract, or agreement; however, if the person satisfied a twelve-month waiting period under such preceding policy, contract, or agreement, the insurer shall waive any preexisting condition exclusion or limitation. The insurer need not waive a preexisting condition exclusion or limitation under the new policy for coverage not provided under such preceding policy, contract, or agreement.

(2) The commissioner may adopt rules establishing guidelines for determining when coverage is similar under new and preceding policies, contracts, and agreements and for determining when a preexisting condition waiting period has been satisfied.

(3) The commissioner in consultation with insurers, health care service contractors, and health maintenance organizations shall study the effect of preexisting condition exclusions and limitations on the cost and availability of health care coverage and shall adopt rules restricting the use of such conditions and limitations by January 1, 1994. No insurer, health care service contractor, or health maintenance organization may deny, exclude, or limit coverage for preexisting conditions for a period longer than that provided for in such rules after July 1, 1994.

Sec. 284. RCW 48.30.300 and 1975-'76 2nd ex.s. c 119 s 7 are each amended to read as follows:

Notwithstanding any provision contained in Title 48 RCW to the contrary:

1 (1) No person or entity engaged in the business of insurance in
2 this state shall refuse to issue any contract of insurance or cancel or
3 decline to renew such contract because of the sex or marital status, or
4 the presence of any sensory, mental, or physical handicap of the
5 insured or prospective insured. The amount of benefits payable, or any
6 term, rate, condition, or type of coverage shall not be restricted,
7 modified, excluded, increased or reduced on the basis of the sex or
8 marital status, or be restricted, modified, excluded or reduced on the
9 basis of the presence of any sensory, mental, or physical handicap of
10 the insured or prospective insured. Subject to the provisions of
11 subsection (2) of this section these provisions shall not prohibit fair
12 discrimination on the basis of sex, or marital status, or the presence
13 of any sensory, mental, or physical handicap when bona fide statistical
14 differences in risk or exposure have been substantiated.
15 (2) With respect to disability policies issued or renewed on or
16 after July 1, 1994, that provide coverage against loss arising from
17 medical, surgical, hospital, or emergency care services:
18 (a) Policies shall guarantee continuity of coverage. Such
19 provision, which shall be included in every policy, shall provide that:
20 (i) The policy may be canceled or nonrenewed without the prior
21 written approval of the commissioner only for nonpayment of premium or
22 as permitted under RCW 48.18.090; and
23 (ii) The policy may be canceled or nonrenewed because of a change
24 in the physical or mental condition or health of a covered person only
25 with the prior written approval of the commissioner. Such approval
26 shall be granted only when the insurer has discharged its obligation to
27 continue coverage for such person by obtaining coverage with another
28 insurer, health care service contractor, or health maintenance
29 organization, which coverage is comparable in terms of premiums and
30 benefits as defined by rule of the commissioner.
31 (b) It is an unfair practice for a disability insurer to modify the
32 coverage provided or rates applying to an in-force disability insurance
33 policy and to fail to make such modification in all such issued and
34 outstanding policies.
35 (c) Subject to rules adopted by the commissioner, it is an unfair
36 practice for a disability insurer to:
37 (i) Cease the sale of a policy form unless it has received prior
38 written authorization from the commissioner and has offered all

policyholders covered under such discontinued policy the opportunity to purchase comparable coverage without health screening; or

(ii) Engage in a practice that subjects policyholders to rate increases on discontinued policy forms unless such policyholders are offered the opportunity to purchase comparable coverage without health screening.

The insurer may limit an offer of comparable coverage without health screening to a period not less than thirty days from the date the offer is first made.

NEW SECTION. **Sec. 285.** A new section is added to chapter 48.44 RCW to read as follows:

(1) With respect to all health care service contracts issued or renewed on or after July 1, 1994, except limited health care service contracts as defined in RCW 48.44.035:

(a) Contracts shall guarantee continuity of coverage. Such provision, which shall be included in every contract, shall provide that:

(i) The contract may be canceled or nonrenewed without the prior written approval of the commissioner only for nonpayment of premiums, for violation of published policies of the contractor which have been approved by the commissioner, for persons who are entitled to become eligible for medicare benefits and fail to subscribe to a medicare supplement plan offered by the contractor, for failure of such subscriber to pay any deductible or copayment amount owed to the contractor and not the provider of health care services, for fraud, or for a material breach of the contract; and

(ii) The contract may be canceled or nonrenewed because of a change in the physical or mental condition or health of a covered person only with the prior written approval of the commissioner. Such approval shall be granted only when the contractor has discharged its obligation to continue coverage for such person by obtaining coverage with another insurer, health care service contractor, or health maintenance organization, which coverage is comparable in terms of premiums and benefits as defined by rule of the commissioner.

(b) It is an unfair practice for a contractor to modify the coverage provided or rates applying to an in-force contract and to fail to make such modification in all such issued and outstanding contracts.

1 (c) Subject to rules adopted by the commissioner, it is an unfair
2 practice for a health care service contractor to:
3 (i) Cease the sale of a contract form unless it has received prior
4 written authorization from the commissioner and has offered all
5 subscribers covered under such discontinued contract the opportunity to
6 purchase comparable coverage without health screening; or
7 (ii) Engage in a practice that subjects subscribers to rate
8 increases on discontinued contract forms unless such subscribers are
9 offered the opportunity to purchase comparable coverage without health
10 screening.
11 (2) The health care service contractor may limit an offer of
12 comparable coverage without health screening to a period not less than
13 thirty days from the date the offer is first made.

14 NEW SECTION. **Sec. 286.** A new section is added to chapter 48.46
15 RCW to read as follows:
16 (1) With respect to all health maintenance agreements issued or
17 renewed on or after July 1, 1994, and in addition to the restrictions
18 and limitations contained in RCW 48.46.060(4):
19 (a) Agreements shall guarantee continuity of coverage. Such
20 provision, which shall be included in every agreement, shall provide
21 that the agreement may be canceled or nonrenewed because of a change in
22 the physical or mental condition or health of a covered person only
23 with the prior written approval of the commissioner. Such approval
24 shall be granted only when the organization has discharged its
25 obligation to continue coverage for such person by obtaining coverage
26 with another insurer, health care service contractor, or health
27 maintenance organization, which coverage is comparable in terms of
28 premiums and benefits as defined by rule of the commissioner.
29 (b) It is an unfair practice for an organization to modify the
30 coverage provided or rates applying to an in-force agreement and to
31 fail to make such modification in all such issued and outstanding
32 agreements.
33 (c) Subject to rules adopted by the commissioner, it is an unfair
34 practice for a health maintenance organization to:
35 (i) Cease the sale of an agreement form unless it has received
36 prior written authorization from the commissioner and has offered all
37 enrollees covered under such discontinued agreement the opportunity to
38 purchase comparable coverage without health screening; or

(ii) Engage in a practice that subjects enrollees to rate increases on discontinued agreement forms unless such enrollees are offered the opportunity to purchase comparable coverage without health screening.

(2) The health maintenance organization may limit an offer of comparable coverage without health screening to a period not less than thirty days from the date the offer is first made.

Sec. 287. RCW 48.44.260 and 1979 c 133 s 3 are each amended to read as follows:

Every authorized health care service contractor, upon canceling, denying, or refusing to renew any individual health care service contract, shall, upon written request, directly notify in writing the applicant or ((~~insured~~)) subscriber, as the case may be, of the reasons for the action by the health care service contractor. Any benefits, terms, rates, or conditions of such a contract which are restricted, excluded, modified, increased, or reduced ((~~because of the presence of a sensory, mental, or physical handicap~~)) shall, upon written request, be set forth in writing and supplied to the ((~~insured~~)) subscriber. The written communications required by this section shall be phrased in simple language which is readily understandable to a person of average intelligence, education, and reading ability.

Sec. 288. RCW 48.46.380 and 1983 c 106 s 16 are each amended to read as follows:

Every authorized health maintenance organization, upon canceling, denying, or refusing to renew any individual health maintenance agreement, shall, upon written request, directly notify in writing the applicant or enrolled participant as appropriate, of the reasons for the action by the health maintenance organization. Any benefits, terms, rates, or conditions of such agreement which are restricted, excluded, modified, increased, or reduced ((~~because of the presence of a sensory, mental, or physical handicap~~)) shall, upon written request, be set forth in writing and supplied to the individual. The written communications required by this section shall be phrased in simple language which is readily understandable to a person of average intelligence, education, and reading ability.

NEW SECTION. **Sec. 289.** The following acts or parts of acts are each repealed:

(1) RCW 48.46.160 and 1975 1st ex.s. c 290 s 17; and

(2) RCW 48.46.905 and 1975 1st ex.s. c 290 s 25.

NEW SECTION. **Sec. 290.** RCW 48.44.410 and 1986 c 223 s 12 are each repealed, effective July 1, 1994.

NEW SECTION. **Sec. 291.** A new section is added to chapter 48.20 RCW to read as follows:

Whenever the provisions of this chapter governing the sale and content of disability insurance conflict with the provision of sections 401 through 409 and 425 through 456 of this act, sections 401 through 409 and 425 through 456 of this act shall control.

NEW SECTION. **Sec. 292.** A new section is added to chapter 48.21 RCW to read as follows:

Whenever the provisions of this chapter governing the sale and content of disability insurance conflict with the provision of sections 401 through 409 and 425 through 456 of this act, sections 401 through 409 and 425 through 456 of this act shall control.

NEW SECTION. **Sec. 293.** A new section is added to chapter 48.44 RCW to read as follows:

Whenever the provisions of this chapter governing the sale and content of health care service contracts conflict with the provision of sections 401 through 409 and 425 through 456 of this act, sections 401 through 409 and 425 through 456 of this act shall control.

NEW SECTION. **Sec. 294.** A new section is added to chapter 48.46 RCW to read as follows:

Whenever the provisions of this chapter governing the sale and content of health maintenance agreements conflict with the provision of sections 401 through 409 and 425 through 456 of this act, sections 401 through 409 and 425 through 456 of this act shall control.

Sec. 295. RCW 48.44.095 and 1983 c 202 s 3 are each amended to read as follows:

(1) Every health care service contractor shall annually, ((~~within one hundred twenty days of the closing date of its fiscal year~~)) before the first day of March, file with the commissioner a statement verified

by at least two of the principal officers of the health care service contractor showing its financial condition as of the ((~~closing date of its fiscal year~~)) last day of the preceding calendar year. The statement shall be in such form as is furnished or prescribed by the commissioner. The commissioner may for good reason allow a reasonable extension of the time within which such annual statement shall be filed.

(2) The commissioner may suspend or revoke the certificate of registration of any health care service contractor failing to file its annual statement when due or during any extension of time therefor which the commissioner, for good cause, may grant.

Sec. 296. RCW 48.46.080 and 1983 c 202 s 10 and 1983 c 106 s 6 are each reenacted and amended to read as follows:

(1) Every health maintenance organization shall annually, ((~~within one hundred twenty days of the closing date of its fiscal year~~)) before the first day of March, file with the commissioner a statement verified by at least two of the principal officers of the health maintenance organization showing its financial condition as of the ((~~closing date of its fiscal year~~)) last day of the preceding calendar year.

(2) Such annual report shall be in such form as the commissioner shall prescribe and shall include:

(a) A financial statement of such organization, including its balance sheet and receipts and disbursements for the preceding year, which reflects at a minimum;

(i) all prepayments and other payments received for health care services rendered pursuant to health maintenance agreements;

(ii) expenditures to all categories of health care facilities, providers, insurance companies, or hospital or medical service plan corporations with which such organization has contracted to fulfill obligations to enrolled participants arising out of its health maintenance agreements, together with all other direct expenses including depreciation, enrollment, and commission; and

(iii) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation, or purchase of facilities and capital equipment;

(b) The number of participants enrolled and terminated during the report period. Every employer offering health care benefits to their employees through a group contract with a health maintenance

organization shall furnish said health maintenance organization with a list of their employees enrolled under such plan;

(c) The number of doctors by type of practice who, under contract with or as an employee of the health maintenance organization, furnished health care services to consumers during the past year;

(d) A report of the names and addresses of all officers, directors, or trustees of the health maintenance organization during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to such organization. For partnership and professional service corporations, a report shall be made for partners or shareholders as to any compensation or expense reimbursement received by them for services, other than for services and expenses relating directly for patient care;

(e) Such other information relating to the performance of the health maintenance organization or the health care facilities or providers with which it has contracted as reasonably necessary to the proper and effective administration of this chapter, in accordance with rules and regulations; and

(f) Disclosure of any financial interests held by officers and directors in any providers associated with the health maintenance organization or any provider of the health maintenance organization.

(3) The commissioner may for good reason allow a reasonable extension of the time within which such annual statement shall be filed.

(4) The commissioner may suspend or revoke the certificate of registration of any health maintenance organization failing to file its annual statement when due or during any extension of time therefor which the commissioner, for good cause, may grant.

(5) No person shall knowingly file with any public official or knowingly make, publish, or disseminate any financial statement of a health maintenance organization which does not accurately state the health maintenance organization's financial condition.

PART III. TAXES AND APPROPRIATIONS

Sec. 301. RCW 82.24.020 and 1989 c 271 s 504 are each amended to read as follows:

(1) There is levied and there shall be collected as hereinafter provided, a tax upon the sale, use, consumption, handling, possession

or distribution of all cigarettes, in an amount equal to the rate of eleven and one-half mills per cigarette.

(2) Until July 1, 1995, an additional tax is imposed upon the sale, use, consumption, handling, possession, or distribution of all cigarettes, in an amount equal to the rate of one and one-half mills per cigarette. All revenues collected during any month from this additional tax shall be deposited in the drug enforcement and education account under RCW 69.50.520 by the twenty-fifth day of the following month.

(3) An additional tax is imposed upon the sale, use, consumption, handling, possession, or distribution of all cigarettes, in an amount equal to the rate of ten mills per cigarette through June 30, 1994, eleven and one-fourth mills per cigarette for the period July 1, 1994, through June 30, 1995, twenty mills per cigarette for the period July 1, 1995, through June 30, 1996, and twenty and one-half mills per cigarette thereafter. All revenues collected during any month from this additional tax shall be deposited in the health services account created under section 459 of this act.

(4) Wholesalers and retailers subject to the payment of this tax may, if they wish, absorb one-half mill per cigarette of the tax and not pass it on to purchasers without being in violation of this section or any other act relating to the sale or taxation of cigarettes.

((~~(4)~~)) (5) For purposes of this chapter, "possession" shall mean both (a) physical possession by the purchaser and, (b) when cigarettes are being transported to or held for the purchaser or his or her designee by a person other than the purchaser, constructive possession by the purchaser or his designee, which constructive possession shall be deemed to occur at the location of the cigarettes being so transported or held.

Sec. 302. RCW 82.24.080 and 1972 ex.s. c 157 s 4 are each amended to read as follows:

It is the intent and purpose of this chapter to levy a tax on all of the articles taxed herein, sold, used, consumed, handled, possessed, or distributed within this state and to collect the tax from the person who first sells, uses, consumes, handles, possesses (either physically or constructively, in accordance with RCW 82.24.020) or distributes them in the state. It is further the intent and purpose of this chapter that whenever any of the articles herein taxed is given away

1 for advertising or any other purpose, it shall be taxed in the same
2 manner as if it were sold, used, consumed, handled, possessed, or
3 distributed in this state.
4 It is also the intent and purpose of this chapter that the tax
5 shall be imposed at the time and place of the first taxable event
6 occurring within this state: PROVIDED, HOWEVER, That failure to pay
7 the tax with respect to a taxable event shall not prevent tax liability
8 from arising by reason of a subsequent taxable event.
9 In the event of an increase in the rate of the tax imposed under
10 this chapter, it is the intent of the legislature that the first person
11 who sells, uses, consumes, handles, possesses, or distributes
12 previously taxed articles after the effective date of the rate increase
13 shall be liable for the additional tax represented by the rate
14 increase, but the failure to pay the additional tax with respect to the
15 first taxable event after the effective date of a rate increase shall
16 not prevent tax liability for the additional tax from arising from a
17 subsequent taxable event.

18 **Sec. 303.** RCW 82.26.020 and 1983 2nd ex.s. c 3 s 16 are each
19 amended to read as follows:
20 (1) ((~~From and after June 1, 1971,~~)) There is levied and there
21 shall be collected a tax upon the sale, use, consumption, handling, or
22 distribution of all tobacco products in this state at the rate of
23 forty-five percent of the wholesale sales price of such tobacco
24 products. ((~~Such tax~~))
25 (2) Taxes under this section shall be imposed at the time the
26 distributor (a) brings, or causes to be brought, into this state from
27 without the state tobacco products for sale, (b) makes, manufactures,
28 or fabricates tobacco products in this state for sale in this state, or
29 (c) ships or transports tobacco products to retailers in this state, to
30 be sold by those retailers.
31 ((~~(2)~~)) (3) An additional tax is imposed equal to ((~~the rate~~
32 ~~specified in RCW 82.02.030~~)) seven percent multiplied by the tax
33 payable under subsection (1) of this section.
34 (4) An additional tax is imposed equal to the tax payable under
35 subsection (1) of this section multiplied by the rate of eighty-five
36 percent through June 30, 1994, ninety-five percent for the period July
37 1, 1994, through June 30, 1995, one hundred seventy percent for the
38 period July 1, 1995, through June 30, 1996, and one hundred seventy-

five percent thereafter. The moneys collected under this subsection shall be deposited in the health services account created under section 459 of this act.

Sec. 304. RCW 82.08.150 and 1989 c 271 s 503 are each amended to read as follows:

(1) There is levied and shall be collected a tax upon each retail sale of spirits, or strong beer in the original package at the rate of fifteen percent of the selling price. The tax imposed in this subsection shall apply to all such sales including sales by the Washington state liquor stores and agencies, but excluding sales to class H licensees.

(2) There is levied and shall be collected a tax upon each sale of spirits, or strong beer in the original package at the rate of ten percent of the selling price on sales by Washington state liquor stores and agencies to class H licensees.

(3) There is levied and shall be collected an additional tax upon each retail sale of spirits in the original package at the rate of one dollar and seventy-two cents per liter. The additional tax imposed in this subsection shall apply to all such sales including sales by Washington state liquor stores and agencies, and including sales to class H licensees.

(4) An additional tax is imposed equal to ((the rate specified in RCW 82.02.030)) fourteen percent multiplied by the taxes payable under subsections (1), (2), and (3) of this section.

(5) Until July 1, 1995, an additional tax is imposed upon each retail sale of spirits in the original package at the rate of seven cents per liter. The additional tax imposed in this subsection shall apply to all such sales including sales by Washington state liquor stores and agencies, and including sales to class H licensees. All revenues collected during any month from this additional tax shall be deposited in the drug enforcement and education account under RCW 69.50.520 by the twenty-fifth day of the following month.

(6) An additional tax is imposed equal to the taxes payable under subsections (1), (2), and (3) of this section multiplied by the rate of eight and eight-tenths percent through June 30, 1995, fifty percent for the period July 1, 1995, through June 30, 1997, and seventy-five percent thereafter. All revenues collected during any month from this

additional tax shall be deposited in the health services account created under section 459 of this act.

(7) The tax imposed in RCW 82.08.020, as now or hereafter amended, shall not apply to sales of spirits or strong beer in the original package.

(((7))) (8) The taxes imposed in this section shall be paid by the buyer to the seller, and each seller shall collect from the buyer the full amount of the tax payable in respect to each taxable sale under this section. The taxes required by this section to be collected by the seller shall be stated separately from the selling price and for purposes of determining the tax due from the buyer to the seller, it shall be conclusively presumed that the selling price quoted in any price list does not include the taxes imposed by this section.

(((8))) (9) As used in this section, the terms, "spirits," "strong beer," and "package" shall have the meaning ascribed to them in chapter 66.04 RCW.

Sec. 305. RCW 66.24.290 and 1989 c 271 s 502 are each amended to read as follows:

(1) Any brewer or beer wholesaler licensed under this title may sell and deliver beer to holders of authorized licenses direct, but to no other person, other than the board; and every such brewer or beer wholesaler shall report all sales to the board monthly, pursuant to the regulations, and shall pay to the board as an added tax for the privilege of manufacturing and selling the beer within the state a tax of two dollars and sixty cents per barrel of thirty-one gallons on sales to licensees within the state and on sales to licensees within the state of bottled and canned beer shall pay a tax computed in gallons at the rate of two dollars and sixty cents per barrel of thirty-one gallons. Any brewer or beer wholesaler whose applicable tax payment is not postmarked by the twentieth day following the month of sale will be assessed a penalty at the rate of two percent per month or fraction thereof. Each such brewer or wholesaler shall procure from the board revenue stamps representing such tax in form prescribed by the board and shall affix the same to the barrel or package in such manner and in such denominations as required by the board, and shall cancel the same prior to commencing delivery from his or her place of business or warehouse of such barrels or packages. Beer shall be sold by brewers and wholesalers in sealed barrels or packages. The revenue

stamps herein provided for need not be affixed and canceled in the making of resales of barrels or packages already taxed by the affixation and cancellation of stamps as provided in this section.

(2) An additional tax is imposed equal to ((~~the rate specified in RCW 82.02.030~~)) seven percent multiplied by the tax payable under subsection (1) of this section. All revenues collected during any month from this additional tax shall be transferred to the state general fund by the twenty-fifth day of the following month.

(3) Until July 1, 1995, an additional tax is imposed on all beer subject to tax under subsection (1) of this section. The additional tax is equal to two dollars per barrel of thirty-one gallons. All revenues collected during any month from this additional tax shall be deposited in the drug enforcement and education account under RCW 69.50.520 by the twenty-fifth day of the following month.

(4) An additional tax is imposed equal to the tax payable under subsection (1) of this section multiplied by eight and eight-tenths percent through June 30, 1995, fifty percent for the period July 1, 1995, through June 30, 1997, and seventy-five percent thereafter. The additional tax imposed under this subsection does not apply to the sale of the first sixty thousand barrels of beer each year by breweries that are entitled to a reduced rate of tax under 26 U.S.C. Sec. 5051, as existing on the effective date of this section or such subsequent date as may be provided by the board by rule. All revenues collected from the additional tax imposed under this subsection shall be deposited in the health services account created under section 459 of this act.

(5) The tax imposed under this section shall not apply to "strong beer" as defined in this title.

Sec. 306. RCW 82.02.030 and 1990 c 42 s 319 are each amended to read as follows:

((~~(1)~~)) The rate of the additional taxes under RCW 54.28.020(2), 54.28.025(2), 66.24.210(2), ((~~66.24.290(2),~~)) 82.04.2901, 82.16.020(2), ((~~82.26.020(2),~~)) 82.27.020(5), and 82.29A.030(2) shall be seven percent((~~; and~~

~~(2) The rate of the additional taxes under RCW 82.08.150(4) shall be fourteen percent~~)).

NEW SECTION. **Sec. 307.** A new section is added to chapter 82.04 RCW to read as follows:

This chapter does not apply to any health maintenance organization in respect to prepayments for health care services that are taxable under section 308 of this act, to any health care service contractor in respect to prepayments for health care services that are taxable under section 309 of this act, or to any certified health plan in respect to premiums that are taxable under section 310 of this act.

NEW SECTION. **Sec. 308.** A new section is added to chapter 48.14 RCW to read as follows:

(1) Each health maintenance organization, as defined in RCW 48.46.020, shall pay a tax on or before the first day of March of each year to the state treasurer through the insurance commissioner's office on amounts received or collected by the health maintenance organization during the preceding calendar year as prepayments for comprehensive health care services.

(2) The amount of the tax shall be equal to the total amount of all prepayments for comprehensive health care services received by the health maintenance organization during the calendar year multiplied by the rate of six-tenths percent for the period January 1, 1995, through December 31, 1995, and one percent thereafter.

(3) Health maintenance organizations shall prepay their tax liability. The minimum amount of the prepayments shall be percentages of the health maintenance organization's tax obligation for the preceding calendar year recomputed using the rate in effect for the current year. For the prepayment of taxes due during calendar year 1995, the minimum amount of the prepayments shall be percentages of the health maintenance organization's tax obligation that would have been due had the tax been in effect during calendar year 1994. The tax prepayments shall be paid to the state treasurer through the commissioner's office by the due dates and in the following amounts:

(a) On or before June 15, forty-five percent;

(b) On or before September 15, twenty-five percent;

(c) On or before December 15, twenty-five percent.

For good cause demonstrated in writing, the commissioner may approve an amount smaller than the preceding calendar year's tax obligation as recomputed for calculating the health maintenance organization's prepayment obligations for the current tax year.

1 (4) One hundred percent of the moneys collected under this section
2 shall be deposited in the health services account created under section
3 459 of this act.

4 NEW SECTION. **Sec. 309.** A new section is added to chapter 48.14
5 RCW to read as follows:
6 (1) Each health care service contractor, as defined in RCW
7 48.44.010, shall pay a tax on or before the first day of March of each
8 year to the state treasurer through the insurance commissioner's office
9 on amounts received or collected by the health care service contractor
10 during the preceding calendar year as prepayments for health care
11 services.
12 (2) The amount of the tax shall be equal to the total amount of all
13 prepayments for health care services received by the health care
14 service contractor during the calendar year multiplied by the rate of
15 six-tenths percent for the period January 1, 1995, through December 31,
16 1995, and one percent thereafter.
17 (3) Health care service contractors shall prepay their tax
18 liability. The minimum amount of the prepayments shall be percentages
19 of the health care service contractor's tax obligation for the
20 preceding calendar year recomputed using the rate in effect for the
21 current year. For the prepayment of taxes due during calendar year
22 1995, the minimum amount of the prepayments shall be percentages of the
23 health care service contractor's tax obligation that would have been
24 due had the tax been in effect during calendar year 1994. The tax
25 prepayments shall be paid to the state treasurer through the
26 commissioner's office by the due dates and in the following amounts:
27 (a) On or before June 15, forty-five percent;
28 (b) On or before September 15, twenty-five percent;
29 (c) On or before December 15, twenty-five percent.
30 For good cause demonstrated in writing, the commissioner may
31 approve an amount smaller than the preceding calendar year's tax
32 obligation as recomputed for calculating the health care service
33 contractor's prepayment obligations for the current tax year.
34 (4) One hundred percent of the moneys collected under this section
35 shall be deposited in the health services account created under section
36 459 of this act.

NEW SECTION. **Sec. 310.** A new section is added to chapter 48.14 RCW to read as follows:

(1) Each certified health plan established under sections 427 through 444 of this act, shall pay a tax on or before the first day of March of each year to the state treasurer through the insurance commissioner's office on premiums received or collected by the certified health plan during the preceding calendar year.

(2) The amount of the tax shall be equal to the total amount of all premiums collected or received by the certified health plan during the calendar year multiplied by the rate of six-tenths percent for the period January 1, 1995, through December 31, 1995, and one percent thereafter.

(3) Certified health plans shall prepay their tax liability. The minimum amount of the prepayments shall be percentages of the certified health plan's tax obligation for the preceding calendar year recomputed using the rate in effect for the current year: PROVIDED, That for the prepayment of taxes due during calendar year 1995, the minimum amount of the prepayments shall be percentages of the certified health plan's tax obligation that would have been due had the tax been in effect during calendar year 1994. The tax prepayments shall be paid to the state treasurer through the commissioner's office by the due dates and in the following amounts:

(a) On or before June 15, forty-five percent;

(b) On or before September 15, twenty-five percent;

(c) On or before December 15, twenty-five percent.

For good cause demonstrated in writing, the commissioner may approve an amount smaller than the preceding calendar year's tax obligation as recomputed for calculating the certified health plan's prepayment obligations for the current tax year.

(4) One hundred percent of the moneys collected under this section shall be deposited in the health services account created under section 459 of this act.

Sec. 311. RCW 82.04.260 and 1991 c 272 s 15 are each amended to read as follows:

(1) Upon every person engaging within this state in the business of buying wheat, oats, dry peas, dry beans, lentils, triticale, corn, rye and barley, but not including any manufactured or processed products thereof, and selling the same at wholesale; the tax imposed shall be

1 equal to the gross proceeds derived from such sales multiplied by the
2 rate of one one-hundredth of one percent.
3 (2) Upon every person engaging within this state in the business of
4 manufacturing wheat into flour, barley into pearl barley, soybeans into
5 soybean oil, or sunflower seeds into sunflower oil; as to such persons
6 the amount of tax with respect to such business shall be equal to the
7 value of the flour, pearl barley, or oil manufactured, multiplied by
8 the rate of one-eighth of one percent.
9 (3) Upon every person engaging within this state in the business of
10 splitting or processing dried peas; as to such persons the amount of
11 tax with respect to such business shall be equal to the value of the
12 peas split or processed, multiplied by the rate of one-quarter of one
13 percent.
14 (4) Upon every person engaging within this state in the business of
15 manufacturing seafood products which remain in a raw, raw frozen, or
16 raw salted state at the completion of the manufacturing by that person;
17 as to such persons the amount of tax with respect to such business
18 shall be equal to the value of the products manufactured, multiplied by
19 the rate of one-eighth of one percent.
20 (5) Upon every person engaging within this state in the business of
21 manufacturing by canning, preserving, freezing or dehydrating fresh
22 fruits and vegetables; as to such persons the amount of tax with
23 respect to such business shall be equal to the value of the products
24 canned, preserved, frozen or dehydrated multiplied by the rate of
25 three-tenths of one percent.
26 (6) Upon every nonprofit corporation and nonprofit association
27 engaging within this state in research and development, as to such
28 corporations and associations, the amount of tax with respect to such
29 activities shall be equal to the gross income derived from such
30 activities multiplied by the rate of forty-four one-hundredths of one
31 percent.
32 (7) Upon every person engaging within this state in the business of
33 slaughtering, breaking and/or processing perishable meat products
34 and/or selling the same at wholesale only and not at retail; as to such
35 persons the tax imposed shall be equal to the gross proceeds derived
36 from such sales multiplied by the rate of twenty-five one-hundredths of
37 one percent through June 30, 1986, and one-eighth of one percent
38 thereafter.

1 (8) Upon every person engaging within this state in the business of
2 making sales, at retail or wholesale, of nuclear fuel assemblies
3 manufactured by that person, as to such persons the amount of tax with
4 respect to such business shall be equal to the gross proceeds of sales
5 of the assemblies multiplied by the rate of twenty-five one-hundredths
6 of one percent.
7 (9) Upon every person engaging within this state in the business of
8 manufacturing nuclear fuel assemblies, as to such persons the amount of
9 tax with respect to such business shall be equal to the value of the
10 products manufactured multiplied by the rate of twenty-five one-
11 hundredths of one percent.
12 (10) Upon every person engaging within this state in the business
13 of acting as a travel agent; as to such persons the amount of the tax
14 with respect to such activities shall be equal to the gross income
15 derived from such activities multiplied by the rate of twenty-five one-
16 hundredths of one percent.
17 (11) Upon every person engaging within this state in business as an
18 international steamship agent, international customs house broker,
19 international freight forwarder, vessel and/or cargo charter broker in
20 foreign commerce, and/or international air cargo agent; as to such
21 persons the amount of the tax with respect to only international
22 activities shall be equal to the gross income derived from such
23 activities multiplied by the rate of thirty-three one-hundredths of one
24 percent.
25 (12) Upon every person engaging within this state in the business
26 of stevedoring and associated activities pertinent to the movement of
27 goods and commodities in waterborne interstate or foreign commerce; as
28 to such persons the amount of tax with respect to such business shall
29 be equal to the gross proceeds derived from such activities multiplied
30 by the rate of thirty-three one hundredths of one percent. Persons
31 subject to taxation under this subsection shall be exempt from payment
32 of taxes imposed by chapter 82.16 RCW for that portion of their
33 business subject to taxation under this subsection. Stevedoring and
34 associated activities pertinent to the conduct of goods and commodities
35 in waterborne interstate or foreign commerce are defined as all
36 activities of a labor, service or transportation nature whereby cargo
37 may be loaded or unloaded to or from vessels or barges, passing over,
38 onto or under a wharf, pier, or similar structure; cargo may be moved
39 to a warehouse or similar holding or storage yard or area to await

further movement in import or export or may move to a consolidation freight station and be stuffed, unstuffed, containerized, separated or otherwise segregated or aggregated for delivery or loaded on any mode of transportation for delivery to its consignee. Specific activities included in this definition are: Wharfage, handling, loading, unloading, moving of cargo to a convenient place of delivery to the consignee or a convenient place for further movement to export mode; documentation services in connection with the receipt, delivery, checking, care, custody and control of cargo required in the transfer of cargo; imported automobile handling prior to delivery to consignee; terminal stevedoring and incidental vessel services, including but not limited to plugging and unplugging refrigerator service to containers, trailers, and other refrigerated cargo receptacles, and securing ship hatch covers.

(13) Upon every person engaging within this state in the business of disposing of low-level waste, as defined in RCW 43.145.010; as to such persons the amount of the tax with respect to such business shall be equal to the gross income of the business, excluding any fees imposed under chapter 43.200 RCW, multiplied by the rate of fifteen percent.

(a) The rate specified in this subsection shall be reduced to ten percent on May 20, 1991.

(b) The rate specified in this subsection shall be further reduced to five percent on January 1, 1992.

(c) The rate specified in this subsection shall be further reduced to three percent on July 1, 1993.

If the gross income of the taxpayer is attributable to activities both within and without this state, the gross income attributable to this state shall be determined in accordance with the methods of apportionment required under RCW 82.04.460.

(14) Upon every person engaging within this state as an insurance agent, insurance broker, or insurance solicitor licensed under chapter 48.17 RCW; as to such persons, the amount of the tax with respect to such licensed activities shall be equal to the gross income of such business multiplied by the rate of one percent.

(15) Upon every person engaging within this state in business as a hospital, as defined in chapter 70.41 RCW, as to such persons, the amount of tax with respect to such activities shall be equal to the gross income of the business multiplied by the rate of five-tenths of

one percent through June 30, 1995, and one and five-tenths percent thereafter. The moneys collected under this subsection shall be deposited in the health services account created under section 459 of this act.

Sec. 312. RCW 82.04.4289 and 1981 c 178 s 2 are each amended to read as follows:

((~~In computing tax there may be deducted from the measure of tax~~)) This chapter does not apply to amounts derived as compensation for services rendered to patients or from sales of prescription drugs as defined in RCW 82.08.0281 furnished as an integral part of services rendered to patients by ((~~a hospital, as defined in chapter 70.41 RCW, which is operated as a nonprofit corporation,~~)) a kidney dialysis facility operated as a nonprofit corporation, ((~~whether or not operated in connection with a hospital,~~)) nursing homes, and homes for unwed mothers operated as religious or charitable organizations, but only if no part of the net earnings received by such an institution inures directly or indirectly, to any person other than the institution entitled to deduction hereunder. ((~~In no event shall any such deduction be allowed, unless the hospital building is entitled to exemption from taxation under the property tax laws of this state.~~))

NEW SECTION. **Sec. 313.** RCW 82.04.4288 and 1980 c 37 s 9 are each repealed.

NEW SECTION. **Sec. 314.** (1) The sum of one hundred seventy-three million nine hundred thousand dollars, or as much thereof as may be necessary, is appropriated for the biennium ending June 30, 1995, from the health services account to the personal health services account for the purposes of continuing and expanding the basic health plan to state residents with incomes below two hundred percent of poverty by June 30, 1995.

(2) The sum of twenty million dollars, or as much thereof as may be necessary, is appropriated for the biennium ending June 30, 1995, from the health services account to the public health account to be used for the purposes of the public health services improvement plan in section 458 of this act and for the purposes of section 459(2) of this act. These funds shall not be used to supplant existing funds received by

1 local public health departments or health districts from federal,
2 state, local government, private or other sources.

3 (3) The sum of six million five hundred thousand dollars, or as
4 much thereof as may be necessary, is appropriated for the biennium
5 ending June 30, 1995, from the health services account to the health
6 professions, data systems, and research account for the purposes of
7 section 459(3) of this act.

8 (4) The sum of four million dollars, or as much thereof as may be
9 necessary, is appropriated for the biennium ending June 30, 1995, from
10 the health services account to the department of health for the
11 following purposes: Four hundred thousand dollars for preparation of
12 the health personnel resource plan under chapter 28B.125 RCW, one
13 million dollars for community-based health professional recruitment and
14 retention activities under chapter 70.185 RCW, two hundred thousand
15 dollars for the malpractice insurance program under RCW 43.70.460 and
16 43.70.470, one million eight hundred thousand dollars for training of
17 volunteer emergency medical services personnel under chapter 70.168
18 RCW, and four hundred thousand dollars to be distributed as needed for
19 the studies authorized in sections 465 and 466 of this act.

20 (5) The sum of two million three hundred thousand dollars, or as
21 much thereof as may be necessary, is appropriated for the biennium
22 ending June 30, 1995, from the health services account to the
23 University of Washington for the following purposes: Two million
24 dollars for the state-wide family medicine program authorized under
25 chapter 70.112 RCW and three hundred thousand dollars for the training
26 of physician assistants and advanced registered nurse practitioners.

27 (6) The sum of two million dollars, or as much thereof as may be
28 necessary, is appropriated for the biennium ending June 30, 1995, from
29 the health services account to the higher education coordinating board
30 for the purposes of making awards through the health professional
31 scholarship and loan repayment under chapter 28B.115 RCW.

32 (7) The sum of five million dollars, or as much thereof as may be
33 necessary, is appropriated for the biennium ending June 30, 1995, from
34 the health services account to the health care authority exclusively
35 for the purposes of increasing the number of migrant, homeless,
36 refugee, and other persons receiving primary health care services
37 through community or migrant health clinics. These funds are intended
38 as an increase over the funding levels provided for in the biennium
39 ending June 30, 1993. These funds shall not be used to supplant

1 existing funds received by community or migrant health clinics from
2 federal, state, local government, private, and other sources.
3 (8) The sum of two hundred fifty thousand dollars, or as much
4 thereof as may be necessary, is appropriated for the biennium ending
5 June 30, 1995, from the health services account to the office of
6 financial management for the purposes of section 406(26) of this act.

7 **PART IV. HEALTH AND MEDICAL SYSTEM REFORM**

8 NEW SECTION. **Sec. 401.** INTENT. The legislature intends that
9 chapter . . ., Laws of 1993 (this act) establish structures, processes,
10 and specific financial limits to stabilize the overall cost of medical
11 care within the economy, reduce the demand for unneeded medical care,
12 provide access to essential health and medical services, improve public
13 health, and ensure that medical system costs do not undermine the
14 financial viability of nonmedical care businesses.

15 NEW SECTION. **Sec. 402.** DEFINITIONS. In this chapter, unless the
16 context otherwise requires:
17 (1)(a) "Certified health plan" or "plan" means a disability insurer
18 regulated under chapter 48.20 or 48.21 RCW, a health care service
19 contractor as defined in RCW 48.44.010, a health maintenance
20 organization as defined in RCW 48.46.020, or an entity certified in
21 accordance with sections 432 through 443 of this act which insurer,
22 contractor, health maintenance organization, or entity contracts to
23 administer or provide the uniform benefits package in a managed care
24 setting consistent with the requirements of this chapter.
25 (b) "Certified health plan" or "plan" also means an employee health
26 benefits plan maintained by an employer who self-insures such benefits
27 and chooses to comply with sections 432 through 443 of this act.
28 (2) "Chair" means the presiding officer of the Washington health
29 services commission.
30 (3) "Commission" means the Washington health services commission.
31 (4) "Community rate" means the rating method used to establish the
32 premium for the uniform benefits package adjusted to reflect
33 actuarially demonstrated differences in utilization or cost
34 attributable to geographic region and family size as determined by the
35 commission.

(5) "Continuous quality improvement and total quality management" means a continuous process to improve health services while reducing costs.

(6) "Employee" means a resident who is in the employment of an employer, as defined by chapter 50.04 RCW. A qualified employee for full employer contributions is an employee who is employed at least eighty hours during a calendar month, two hundred forty hours during a calendar quarter, or nine hundred sixty hours during a calendar year. A part-time employee is an employee who is employed less than eighty hours during a calendar month, two hundred forty hours during a calendar quarter, or nine hundred sixty hours during a calendar year.

(7) "Enrollee" means any person who is a Washington resident enrolled in a certified health plan.

(8) "Enrollee point of service cost-sharing" means copayments or coinsurance paid to certified health plans directly providing services, health care providers, or health care facilities by enrollees for receipt of specific uniform benefits package services, within limits established by the commission.

(9) "Enrollee premium sharing" means that portion of the premium, determined by the commission, that is paid by enrollees or their family members.

(10) "Federal poverty level" means the federal poverty guidelines determined annually by the United States department of health and human services or successor agency.

(11) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations, but does not include Christian Science sanatoriums operated, listed, or certified by the First Church of Christ Scientist, Boston, Massachusetts.

(12) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(13) "Health insurance purchasing cooperative" or "cooperative" means a member-owned and governed nonprofit organization certified in accordance with sections 425 and 426 of this act.

(14) "Long-term care" means institutional, residential, outpatient, or community-based services that meet the individual needs of persons of all ages who are limited in their functional capacities or have disabilities and require assistance with performing two or more activities of daily living for an extended or indefinite period of time. These services include case management, protective supervision, in-home care, nursing services, convalescent, custodial, chronic, and terminally ill care.

(15) "Major capital expenditure" means any single expenditure for capital construction, renovations, or acquisition, including medical technological equipment, as defined by the commission, costing more than one million dollars.

(16) "Managed care" means an integrated system of insurance, financing, and health services delivery functions that assumes financial risk for delivery of health services and that uses a defined network of providers or that promotes the efficient delivery of health services through provider assumption of some financial risk including capitation, prospective payment, resource-based relative value scales, fee schedules, or similar method of limiting payments to health care providers, excluding fee for service.

(17) "Maximum enrollee financial participation" means the income-related total annual payments that may be required of an enrollee per family who chooses one of the three lowest priced plans in a geographic region including both premium-sharing and enrollee point of service cost-sharing.

(18) "Persons of color" means Asians/Pacific Islanders, African, Hispanic, and Native Americans.

(19) "Premium" means all sums charged, received, or deposited by a certified health plan as consideration for a uniform benefits package or the continuance of a uniform benefits package. Any assessment, or

1 any "membership," "policy," "contract," "service," or similar fee or
2 charge made by the certified health plan in consideration for the
3 uniform benefits package is deemed part of the premium.
4 (20) "Supplemental benefits" means those appropriate and effective
5 health services, defined by the commission, in accordance with section
6 452 of this act, that expand coverage under the uniform benefits
7 package and that may be offered to all Washington residents through
8 certified health plans.
9 (21) "Technology" means the drugs, devices, equipment, and medical
10 or surgical procedures used in the delivery of health services, and the
11 organizational or supportive systems within which such services are
12 provided. It also means sophisticated and complicated machinery
13 developed as a result of ongoing research in the basic biological and
14 physical sciences, clinical medicine, electronics, and computer
15 sciences, as well as specialized professionals, medical equipment,
16 procedures, and chemical formulations used for both diagnostic and
17 therapeutic purposes.
18 (22) "Uniform benefits package" or "package" means those
19 appropriate and effective health services, defined by the commission
20 under section 448 of this act, that must be offered to all Washington
21 residents through certified health plans.
22 (23) "Washington resident" or "resident" means a person who intends
23 to reside in the state permanently or indefinitely and who did not move
24 to Washington for the primary purpose of securing health services under
25 sections 427 through 456 of this act. "Washington resident" also
26 includes people and their accompanying family members who are in the
27 state for the purpose of engaging in employment for at least one month,
28 who did not enter the state for the primary purpose of obtaining health
29 services. The confinement of a person in a nursing home, hospital, or
30 other medical institution in the state shall not by itself be
31 sufficient to qualify such person as a resident.

32 **A. THE WASHINGTON HEALTH SERVICES COMMISSION**

33 NEW SECTION. **Sec. 403.** CREATION OF COMMISSION--MEMBERSHIP--TERMS
34 OF OFFICE--VACANCIES--SALARIES. (1) There is created an agency of
35 state government to be known as the Washington health services
36 commission. The commission shall consist of five members reflecting
37 ethnic and racial diversity, appointed by the governor, with the

1 consent of the senate. One member shall be designated by the governor
2 as chair and shall serve at the pleasure of the governor. The
3 insurance commissioner, or his or her designee, shall serve as a
4 nonvoting member. Of the initial members, one shall be appointed to a
5 term of three years, one shall be appointed to a term of four years,
6 and one shall be appointed to a term of five years. Thereafter,
7 members shall be appointed to five-year terms. Vacancies shall be
8 filled by appointment for the remainder of the unexpired term of the
9 position being vacated.
10 (2) Members of the commission shall have no pecuniary interest in
11 any business subject to regulation by the commission and shall be
12 subject to chapter 42.18 RCW, the executive branch conflict of interest
13 act.
14 (3) Members of the commission shall occupy their positions on a
15 full-time basis and are exempt from the provisions of chapter 41.06
16 RCW. Commission members and the professional commission staff are
17 subject to the public disclosure provisions of chapter 42.17 RCW.
18 Members shall be paid a salary to be fixed by the governor in
19 accordance with RCW 43.03.040. A majority of the members of the
20 commission constitutes a quorum for the conduct of business.

21 NEW SECTION. **Sec. 404.** STAKEHOLDERS' COMMITTEE. (1)(a) In an
22 effort to ensure effective participation in the commission's
23 deliberations, the chair shall appoint a stakeholders' committee with
24 a balanced representation of members representing consumers, business,
25 government, labor, insurers, health care providers, health care service
26 contractors, health maintenance organizations, and persons of color.
27 The chair may also appoint ad hoc and special committees for a
28 specified time period.
29 (b) The chair shall also appoint health services effectiveness
30 panels for specified periods of time to provide technical guidance
31 related to appropriate and effective health services, use of technology
32 and practice guidelines, and development of the uniform benefits
33 package. Panels should include technical experts, such as general
34 practitioners, specialty physicians or providers, health service
35 researchers, health ethicists, epidemiologists, and public health
36 experts who reflect the state's ethnic and cultural diversity.
37 (c) The commission shall also appoint a small business advisory
38 committee composed of seven small business owners to assist the

commission in development of the small business economic impact statement, as provided in section 448(7) of this act.

(2) Members of committees and panels shall serve without compensation for their services but shall be reimbursed for their expenses while attending meetings on behalf of the commission in accordance with RCW 43.03.050 and 43.03.060.

NEW SECTION. **Sec. 405.** POWERS AND DUTIES OF THE CHAIR. The chair shall be the chief administrative officer and the appointing authority of the commission and has the following powers and duties:

(1) Direct and supervise the commission's administrative and technical activities in accordance with the provisions of this chapter and rules and policies adopted by the commission;

(2) Employ personnel of the commission, representative of ethnic diversity, in accordance with chapter 41.06 RCW, and prescribe their duties. With the approval of a majority of the commission, the chair may appoint persons to administer any entity established pursuant to subsection (8) of this section, and up to seven additional employees all of whom shall be exempt from the provisions of chapter 41.06 RCW;

(3) Enter into contracts on behalf of the commission;

(4) Accept and expend gifts, donations, grants, and other funds received by the commission;

(5) Delegate administrative functions of the commission to employees of the commission as the chair deems necessary to ensure efficient administration;

(6) Subject to approval of the commission, appoint advisory committees and undertake studies, research, and analysis necessary to support activities of the commission;

(7) Preside at meetings of the commission;

(8) Consistent with policies and rules established by the commission, establish such administrative divisions, offices, or programs as are necessary to carry out the purposes of chapter . . ., Laws of 1993 (this act); and

(9) Perform such other administrative and technical duties as are consistent with chapter . . ., Laws of 1993 (this act) and the rules and policies of the commission.

NEW SECTION. **Sec. 406.** POWERS AND DUTIES OF THE COMMISSION. The commission has the following powers and duties:

1 (1) Ensure that all residents of Washington state are enrolled in
2 a certified health plan to receive the uniform benefits package,
3 regardless of age, sex, family structure, ethnicity, race, health
4 condition, geographic location, employment, or economic status.
5 (2) Endeavor to ensure that all residents of Washington state have
6 access to appropriate, timely, confidential, and effective health
7 services. If the commission finds that individuals or populations lack
8 access to certified health plan services, the commission shall:
9 (a) Authorize appropriate state agencies, local health departments,
10 community or migrant health clinics, public hospital districts, or
11 other nonprofit health service entities to take actions necessary to
12 assure such access. This includes authority to contract for or
13 directly deliver services described within the uniform benefits package
14 to special populations; or
15 (b) Notify appropriate certified health plans and the insurance
16 commissioner of such findings. The commission shall adopt by rule
17 standards by which the insurance commissioner may, in such event,
18 require certified health plans in closest proximity to such individuals
19 and populations to extend their catchment areas to those individuals
20 and populations and offer them enrollment.
21 (3) Adopt necessary rules in accordance with chapter 34.05 RCW to
22 carry out the purposes of chapter . . ., Laws of 1993 (this act),
23 provided that an initial set of draft rules establishing at least the
24 commission's organization structure, the uniform benefits package,
25 enrollee and employer financial participation, levels of and standards
26 for certified health plan certification, must be submitted in draft
27 form to appropriate committees of the legislature by December 1, 1994.
28 (4) Establish and modify as necessary, in consultation with the
29 state board of health and the department of health, and coordination
30 with the planning process set forth in section 458 of this act a
31 uniform set of health services based on the recommendations of the
32 health care cost control and access commission.
33 (5) Establish and modify as necessary, the uniform benefits
34 package, as provided in section 448 of this act, which shall be offered
35 to enrollees of a certified health plan. The benefit package shall be
36 provided at no more than the maximum premium specified in subsection
37 (6) of this section.
38 (6)(a) Establish for each year a community-rated maximum premium
39 for the uniform benefits package. The premium cost of the uniform

benefits package in 1995 shall be based upon an actuarial determination of the costs of providing the uniform benefits package, assuming cost savings that may result from reductions in cost shifting, the use of managed care, identification of cost-effective and clinically efficacious services, and any other factors deemed relevant by the commission. Beginning in 1996, the growth rate of the uniform benefits package shall be allowed to increase by a rate no greater than the average growth rate in the cost of the package between 1990 and 1993 as actuarially determined, reduced by two percentage points per year until the growth rate is no greater than growth in Washington per capita personal income, as determined by the office of financial management.

(b) If the commission adds or deletes services or benefits to the uniform benefits package in subsequent years, it may increase or decrease the maximum premium to reflect the actual cost experience of a broad sample of providers of that service in the state, considering the factors enumerated in (a) of this subsection and adjusted actuarially. The addition of services or benefits shall not result in a redetermination of the entire cost of the uniform benefits package.

(7) In order to promote price competition, establish annual premium shares and amounts that shall be paid by employers, government sponsors, and enrollees defined in relation to the price of the lowest priced plan in the region providing the uniform benefits package in a manner that ensures adequate quality of services. Enrollee premium share levels shall be related to enrollee household income and shall not apply to enrollees with income less than the federal poverty level. The commission shall develop mechanisms through which enrollees whose premium share levels are reduced as a result of low household income can obtain subsidies necessary for enrollment in a certified health plan. The availability of subsidies shall be conditioned upon the appropriation of funds specifically for this purpose.

(8) Develop and implement, if necessary, one or more medical risk adjustment mechanisms to minimize financial incentives for certified health plans to enroll individuals who present lower health risks and avoid enrolling individuals who present higher health risks, and to minimize financial incentives for employer hiring practices that discriminate against individuals who present higher health risks. In the design and implementation of medical risk distribution mechanisms under this subsection, the commission shall (a) balance the benefits of price competition with the need to protect certified health plans from

any unsustainable negative effects of adverse selection and (b) consider the development of a system that creates a risk profile of each certified health plan's enrollee population that does not create disincentives for a plan to control benefit utilization, that requires contributions from plans that enjoy a low-risk enrollee population to plans that have a high-risk enrollee population, and that does not permit an adjustment of the premium charged for the uniform benefits package or supplemental coverage based upon either receipt or contribution of assessments.

(9) Design a mechanism to assure minors have access to confidential health care services as currently provided in RCW 70.24.110 and 71.34.030.

(10) Monitor the actual growth in total annual health services costs.

(11) Establish reporting requirements for certified health plans that own or manage health care facilities, health care facilities, and health care providers to periodically report to the commission regarding major capital expenditures of the plans. The commission shall review and monitor such reports from providers and shall report to the legislature regarding major capital expenditures by providers on at least an annual basis.

(12) Establish maximum enrollee financial participation levels. The levels shall be related to enrollee household income and shall not result in household income being reduced below the federal poverty level.

(13) For health services provided under the uniform benefits package, adopt standards for enrollment, and standardized billing and claims processing forms. The standards shall ensure that these procedures minimize administrative burdens on health care providers, certified health plans, and consumers. Subject to federal approval or phase-in schedules whenever necessary or appropriate, the standards also shall apply to state-purchased health services, as defined in RCW 41.05.011.

(14) Suggest that certified health plans adopt certain practice guidelines or risk management protocols for quality assurance, utilization review, or provider payment. The commission may consider guidelines or protocols recommended according to section 410 of this act for these purposes.

1 (15) Suggest other guidelines to certified health plans for
2 utilization management, use of technology and methods of payment, such
3 as diagnosis-related groups and a resource-based relative value scale.
4 Such guidelines shall be voluntary and shall be designed to promote
5 improved management of care, and provide incentives for improved
6 efficiency and effectiveness within the delivery system.
7 (16) Adopt standards and oversee and develop policy for personal
8 health data and information systems as provided in chapter 70.170 RCW.
9 (17) Adopt standards that prevent conflict of interest by health
10 care providers as provided in section 408 of this act.
11 (18) Consider the extent to which medical research activities
12 should be included within the health service system set forth in this
13 chapter . . ., Laws of 1993 (this act).
14 (19) Adopt standards and procedures under which a health care
15 provider, health care facility, enrollee, or certified health plan may
16 seek a prior determination as to whether medical services and related
17 health care services, drugs, and other technologies provided in
18 connection with a particular treatment are included in the uniform
19 benefits package.
20 (20) Evaluate and monitor the extent to which racial and ethnic
21 minorities have access and to receive health services within the state,
22 and develop strategies to address barriers to access.
23 (21) Develop standards for the certification process to certify
24 health plans to provide the uniform benefits package, according to the
25 provisions for certified health plans under chapter . . ., Laws of 1993
26 (this act).
27 (22) Develop rules for implementation of individual and employer
28 participation under sections 454 and 455 of this act specifically
29 applicable to persons who work in this state but do not live in the
30 state or persons who live in this state but work outside of the state.
31 The rules shall be designed so that these persons receive coverage and
32 financial requirements that are comparable to that received by persons
33 who both live and work in the state.
34 (23) Establish a process for purchase of uniform benefits package
35 services by enrollees when they are out-of-state.
36 (24) Develop recommendations to the legislature as to whether state
37 and school district employees, on whose behalf health benefits are or
38 will be purchased by the health care authority pursuant to chapter
39 41.05 RCW, should have the option to purchase health benefits through

health insurance purchasing cooperatives on or after July 1, 1997. In developing its recommendations, the commission shall consider:

(a) The impact of state or school district employees purchasing through health insurance purchasing cooperatives on the ability of the state to control its health care costs; and

(b) Whether state or school district employees purchasing through health insurance purchasing cooperatives will result in inequities in health benefits between or within groups of state and school district employees.

(25) Establish guidelines for providers dealing with terminal or static conditions, taking into consideration the ethics of providers, patient and family wishes, costs, and survival possibilities.

(26) Undertake or facilitate evaluations of health care reform, including analysis of fiscal and economic impacts, the effectiveness of managed care and managed competition, and effects of reform on access and quality of service. Fiscal and economic impact analysis shall be conducted by the office of financial management.

(27) Evaluate the extent to which Taft-Hartley health care trusts provide benefits to certain individuals in the state; review the federal laws under which these joint employee-employer entities are organized; and make appropriate recommendations to the governor and the legislature about how these trusts can be brought under the provisions of chapter . . ., Laws of 1993 (this act) when it is fully implemented.

(28) Evaluate whether Washington is experiencing a higher percentage in in-migration of residents from other states and territories than would be expected by normal trends as a result of the availability of comprehensive subsidized health care benefits for all residents and report to the governor and the legislature their findings.

(29) In developing the uniform benefits package and other standards pursuant to this section, consider the likelihood of the establishment of a national health services plan adopted by the federal government and its implications.

(30) Evaluate the effect of reforms under chapter . . ., Laws of 1993 (this act) on access to care and economic development in rural areas.

To the extent that the exercise of any of the powers and duties specified in this section may be inconsistent with the powers and duties of other state agencies, offices, or commissions, the authority

of the commission shall supersede that of such other state agency, office, or commission, except in matters of personal health data, where the commission shall have primary data system policymaking authority and the department of health shall have primary responsibility for the maintenance and routine operation of personal health data systems.

NEW SECTION. **Sec. 407.** MODIFICATION OF MAXIMUM PREMIUM. Upon the recommendation of the insurance commissioner, and on the basis of evidence established by independent actuarial analysis, if the commission finds that the economic viability of a significant number of the state's certified health plans is seriously threatened, the commission may increase the maximum premium to the extent mandated by the Constitution, and must immediately thereafter submit to the legislature a proposal for a new formula for adjusting the maximum premium that must be approved by each house of the legislature by a sixty percent vote.

NEW SECTION. **Sec. 408.** CONFLICT OF INTEREST STANDARDS. The Washington health services commission established by section 403 of this act, in consultation with the secretary of health, and the health care disciplinary authorities under RCW 18.130.040(2)(b), shall establish standards and monetary penalties in rule prohibiting provider investments and referrals that present a conflict of interest resulting from inappropriate financial gain for the provider or his or her immediate family. These standards are not intended to inhibit the efficient operation of managed health care systems or certified health plans. The commission shall report to the health policy committees of the senate and house of representatives by December 1, 1994, on the development of the standards and any recommended statutory changes necessary to implement the standards.

NEW SECTION. **Sec. 409.** CONTINUOUS QUALITY IMPROVEMENT AND TOTAL QUALITY MANAGEMENT. To ensure the highest quality health services at the lowest total cost, the commission shall establish a total quality management system of continuous quality improvement. Such endeavor shall be based upon the recognized quality science for continuous quality improvement. The commission shall impanel a committee composed of persons from the private sector and related sciences who have broad knowledge and successful experiences in continuous quality improvement

1 and total quality management applications. It shall be the
2 responsibility of the committee to develop standards for a Washington
3 state health services supplier certification process and recommend such
4 standards to the commission for review and adoption. Once adopted, the
5 commission shall establish a schedule, with full compliance no later
6 than July 1, 1996, whereby all health service providers and health
7 service facilities shall be certified prior to providing uniform
8 benefits package services.

9 **B. PRACTICE INDICATORS**

10 NEW SECTION. **Sec. 410.** A new section is added to chapter 43.70
11 RCW to read as follows:
12 PRACTICE INDICATORS. The department of health shall consult with
13 health care providers, purchasers, health professional regulatory
14 authorities under RCW 18.130.040, appropriate research and clinical
15 experts, and consumers of health care services to identify specific
16 practice areas where practice indicators and risk management protocols
17 have been developed, including those that have been demonstrated to be
18 effective among persons of color. Practice indicators shall be based
19 upon expert consensus and best available scientific evidence. The
20 department shall:
21 (1) Develop a definition of expert consensus and best available
22 scientific evidence so that practice indicators can serve as a standard
23 for excellence in the provision of health care services.
24 (2) Establish a process to identify and evaluate practice
25 indicators and risk management protocols as they are developed by the
26 appropriate professional, scientific, and clinical communities.
27 (3) Recommend the use of practice indicators and risk management
28 protocols in quality assurance, utilization review, or provider payment
29 to the health services commission.

30 **C. HEALTH CARE LIABILITY REFORMS**

31 **Sec. 411.** RCW 18.72.400 and 1991 c 3 s 171 are each amended to
32 read as follows:
33 (1) The secretary of health shall allocate all appropriated funds
34 to accomplish the purposes of this chapter.

(2) Upon a showing by the secretary of health, on behalf of the medical disciplinary board, that expenditures in excess of levels authorized by legislative appropriation are necessary to meet unanticipated public demand for investigation of, and disciplinary action against, unsafe or impaired physicians or surgeons, the office of financial management may authorize necessary expenditures from the medical disciplinary account in excess of appropriated levels.

Sec. 412. RCW 43.70.320 and 1991 sp.s. c 13 s 18 are each amended to read as follows:

(1) There is created in the state treasury an account to be known as the health professions account. All fees received by the department for health professions licenses, registration, certifications, renewals, or examinations and the civil penalties assessed and collected by the department under RCW 18.130.190(4) shall be forwarded to the state treasurer who shall credit such moneys to the health professions account.

(2) All expenses incurred in carrying out the health professions licensing activities of the department shall be paid from the account as authorized by legislative appropriation. Upon a showing by the department, on behalf of an individual health profession regulatory board, that expenditures in excess of levels authorized by legislative appropriation are necessary to meet unanticipated public demand for investigation of, and disciplinary action against, unsafe or impaired health care practitioners, the office of financial management may authorize necessary expenditures from the health professions account in excess of appropriated levels. Any residue in the account shall be accumulated and shall not revert to the general fund at the end of the biennium.

(3) The secretary shall biennially prepare a budget request based on the anticipated costs of administering the health professions licensing activities of the department which shall include the estimated income from health professions fees.

NEW SECTION. **Sec. 413.** A new section is added to chapter 18.130 RCW to read as follows:

MALPRACTICE INSURANCE COVERAGE MANDATE. Except to the extent that liability insurance is not available, every licensed health care practitioner whose services are included in the uniform benefits

package, as determined by section 448 of this act, and whose scope of practice includes independent practice, shall, as a condition of licensure and relicensure, be required to provide evidence of a minimum level of malpractice insurance coverage issued by a company authorized to do business in this state. On or before January 1, 1994, the department shall designate by rule:

(1) Those health professions whose scope of practice includes independent practice;

(2) For each health profession whose scope of practice includes independent practice, whether malpractice insurance is available; and

(3) If such insurance is available, the appropriate minimum level of mandated coverage.

NEW SECTION. **Sec. 414.** A new section is added to chapter 48.22 RCW to read as follows:

RISK MANAGEMENT TRAINING OF INDEPENDENT HEALTH CARE PRACTITIONERS. Effective July 1, 1994, a casualty insurer's issuance of a new medical malpractice policy or renewal of an existing medical malpractice policy to a physician or other independent health care practitioner shall be conditioned upon that practitioner's participation in, and completion of, health care liability risk management training. The risk management training shall provide information related to avoiding adverse health outcomes resulting from substandard practice and minimizing damages associated with the adverse health outcomes that do occur. For purposes of this section, "independent health care practitioners" means those health care practitioner licensing classifications designated by the department of health in rule pursuant to section 413 of this act.

NEW SECTION. **Sec. 415.** A new section is added to chapter 48.05 RCW to read as follows:

RISK MANAGEMENT TRAINING OF INDEPENDENT HEALTH CARE PRACTITIONERS. Effective July 1, 1994, each health care provider, facility, or health maintenance organization that self-insures for liability risks related to medical malpractice and employs physicians or other independent health care practitioners in Washington state shall condition each physician's and practitioner's liability coverage by that entity upon that physician's or practitioner's participation in risk management training offered by the provider, facility, or health maintenance

organization to its employees. The risk management training shall provide information related to avoiding adverse health outcomes resulting from substandard practice and minimizing damages associated with those adverse health outcomes that do occur. For purposes of this section, "independent health care practitioner" means those health care practitioner licensing classifications designated by the department of health in rule pursuant to section 413 of this act.

Sec. 416. RCW 70.41.200 and 1991 c 3 s 336 are each amended to read as follows:

(1) Every hospital shall maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. The program shall include at least the following:

(a) The establishment of a quality ((~~assurance~~)) improvement committee with the responsibility to review the services rendered in the hospital, both retrospectively and prospectively, in order to improve the quality of medical care of patients and to prevent medical malpractice. The committee shall oversee and coordinate the quality improvement and medical malpractice prevention program and shall insure that information gathered pursuant to the program is used to review and to revise hospital policies and procedures((~~. At least one member of the committee shall be a member of the governing board of the hospital who is not otherwise affiliated with the hospital in an employment or contractual capacity~~));

(b) A medical staff privileges sanction procedure through which credentials, physical and mental capacity, and competence in delivering health care services are periodically reviewed as part of an evaluation of staff privileges;

(c) The periodic review of the credentials, physical and mental capacity, and competence in delivering health care services of all persons who are employed or associated with the hospital;

(d) A procedure for the prompt resolution of grievances by patients or their representatives related to accidents, injuries, treatment, and other events that may result in claims of medical malpractice;

(e) The maintenance and continuous collection of information concerning the hospital's experience with negative health care outcomes and incidents injurious to patients, patient grievances, professional

liability premiums, settlements, awards, costs incurred by the hospital for patient injury prevention, and safety improvement activities;

(f) The maintenance of relevant and appropriate information gathered pursuant to (a) through (e) of this subsection concerning individual physicians within the physician's personnel or credential file maintained by the hospital;

(g) Education programs dealing with quality improvement, patient safety, injury prevention, staff responsibility to report professional misconduct, the legal aspects of patient care, improved communication with patients, and causes of malpractice claims for staff personnel engaged in patient care activities; and

(h) Policies to ensure compliance with the reporting requirements of this section.

(2) Any person who, in substantial good faith, provides information to further the purposes of the quality improvement and medical malpractice prevention program or who, in substantial good faith, participates on the quality ((~~assurance~~)) improvement committee shall not be subject to an action for civil damages or other relief as a result of such activity.

(3) Information and documents, including complaints and incident reports, created specifically for, and collected, and maintained ((~~about health care providers arising out of the matters that are under review or have been evaluated~~)) by a ((~~review~~)) quality improvement committee ((~~conducting quality assurance reviews~~)) are not subject to discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or ((~~board~~)) who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts which form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; ((~~(b)~~)) (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical

or staff privileges, introduction into evidence information collected and maintained by quality ((~~assurance~~)) improvement committees regarding such health care provider; ((~~(c)~~)) (d) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or ((~~(d)~~)) (e) in any civil action, discovery and introduction into evidence of the patient's medical records required by regulation of the department of health to be made regarding the care and treatment received.

(4) The department of health shall adopt such rules as are deemed appropriate to effectuate the purposes of this section.

(5) The medical disciplinary board or the board of osteopathic medicine and surgery, as appropriate, may review and audit the records of committee decisions in which a physician's privileges are terminated or restricted. Each hospital shall produce and make accessible to the board the appropriate records and otherwise facilitate the review and audit. Information so gained shall not be subject to the discovery process and confidentiality shall be respected as required by subsection (3) of this section. Failure of a hospital to comply with this subsection is punishable by a civil penalty not to exceed two hundred fifty dollars.

(6) Violation of this section shall not be considered negligence per se.

Sec. 417. RCW 70.41.230 and 1991 c 3 s 337 are each amended to read as follows:

(1) Prior to granting or renewing clinical privileges or association of any physician or hiring a physician, a hospital or facility approved pursuant to this chapter shall request from the physician and the physician shall provide the following information:

(a) The name of any hospital or facility with or at which the physician had or has any association, employment, privileges, or practice;

(b) If such association, employment, privilege, or practice was discontinued, the reasons for its discontinuation;

(c) Any pending professional medical misconduct proceedings or any pending medical malpractice actions in this state or another state, the substance of the allegations in the proceedings or actions, and any

1 additional information concerning the proceedings or actions as the
2 physician deems appropriate;
3 (d) The substance of the findings in the actions or proceedings and
4 any additional information concerning the actions or proceedings as the
5 physician deems appropriate;
6 (e) A waiver by the physician of any confidentiality provisions
7 concerning the information required to be provided to hospitals
8 pursuant to this subsection; and
9 (f) A verification by the physician that the information provided
10 by the physician is accurate and complete.
11 (2) Prior to granting privileges or association to any physician or
12 hiring a physician, a hospital or facility approved pursuant to this
13 chapter shall request from any hospital with or at which the physician
14 had or has privileges, was associated, or was employed, the following
15 information concerning the physician:
16 (a) Any pending professional medical misconduct proceedings or any
17 pending medical malpractice actions, in this state or another state;
18 (b) Any judgment or settlement of a medical malpractice action and
19 any finding of professional misconduct in this state or another state
20 by a licensing or disciplinary board; and
21 (c) Any information required to be reported by hospitals pursuant
22 to RCW 18.72.265.
23 (3) The medical disciplinary board shall be advised within thirty
24 days of the name of any physician denied staff privileges, association,
25 or employment on the basis of adverse findings under subsection (1) of
26 this section.
27 (4) A hospital or facility that receives a request for information
28 from another hospital or facility pursuant to subsections (1) and (2)
29 of this section shall provide such information concerning the physician
30 in question to the extent such information is known to the hospital or
31 facility receiving such a request, including the reasons for
32 suspension, termination, or curtailment of employment or privileges at
33 the hospital or facility. A hospital, facility, or other person
34 providing such information in good faith is not liable in any civil
35 action for the release of such information.
36 (5) Information and documents, including complaints and incident
37 reports, created specifically for, and collected, and maintained
38 ((~~about health care providers arising out of the matters that are under~~
39 ~~review or have been evaluated~~)) by a ((~~review~~)) quality improvement

committee ((~~conducting quality assurance reviews~~)) are not subject to discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or ((~~board~~)) who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts which form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; ((~~(b)~~)) (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality ((~~assurance~~)) improvement committees regarding such health care provider; ((~~(c)~~)) (d) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or ((~~(d)~~)) (e) in any civil action, discovery and introduction into evidence of the patient's medical records required by regulation of the department of health to be made regarding the care and treatment received.

(6) Hospitals shall be granted access to information held by the medical disciplinary board and the board of osteopathic medicine and surgery pertinent to decisions of the hospital regarding credentialing and recredentialing of practitioners.

(7) Violation of this section shall not be considered negligence per se.

NEW SECTION. **Sec. 418.** A new section is added to chapter 43.70 RCW to read as follows:

COORDINATED QUALITY IMPROVEMENT PROGRAM. (1)(a) Health care institutions and medical facilities, other than hospitals, that are licensed by the department, professional societies or organizations, and certified health plans approved pursuant to section 428 of this act may maintain a coordinated quality improvement program for the

1 improvement of the quality of health care services rendered to patients
2 and the identification and prevention of medical malpractice as set
3 forth in RCW 70.41.200.
4 (b) All such programs shall comply with the requirements of RCW
5 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to
6 reflect the structural organization of the institution, facility,
7 professional societies or organizations, or certified health plan,
8 unless an alternative quality improvement program substantially
9 equivalent to RCW 70.41.200(1)(a) is developed. All such programs,
10 whether complying with the requirement set forth in RCW 70.41.200(1)(a)
11 or in the form of an alternative program, must be approved by the
12 department before the discovery limitations provided in subsections (3)
13 and (4) of this section shall apply. In reviewing plans submitted by
14 licensed entities that are associated with physicians' offices, the
15 department shall ensure that the discovery limitations of this section
16 are applied only to information and documents related specifically to
17 quality improvement activities undertaken by the licensed entity.
18 (2) Health care provider groups of ten or more providers may
19 maintain a coordinated quality improvement program for the improvement
20 of the quality of health care services rendered to patients and the
21 identification and prevention of medical malpractice as set forth in
22 RCW 70.41.200. All such programs shall comply with the requirements of
23 RCW 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to
24 reflect the structural organization of the health care provider group.
25 All such programs must be approved by the department before the
26 discovery limitations provided in subsections (3) and (4) of this
27 section shall apply.
28 (3) Any person who, in substantial good faith, provides information
29 to further the purposes of the quality improvement and medical
30 malpractice prevention program or who, in substantial good faith,
31 participates on the quality improvement committee shall not be subject
32 to an action for civil damages or other relief as a result of such
33 activity.
34 (4) Information and documents, including complaints and incident
35 reports, created specifically for, and collected, and maintained by a
36 quality improvement committee are not subject to discovery or
37 introduction into evidence in any civil action, and no person who was
38 in attendance at a meeting of such committee or who participated in the
39 creation, collection, or maintenance of information or documents

specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts that form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality improvement committees regarding such health care provider; (d) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or (e) in any civil action, discovery and introduction into evidence of the patient's medical records required by rule of the department of health to be made regarding the care and treatment received.

(5) The department of health shall adopt rules as are necessary to implement this section.

NEW SECTION. **Sec. 419.** MEDICAL MALPRACTICE REVIEW. (1) The administrator for the courts shall coordinate a collaborative effort to develop a voluntary system for review of medical malpractice claims by health services experts prior to the filing of a cause of action under chapter 7.70 RCW.

(2) The system shall have at least the following components:

(a) Review would be initiated, by agreement of the injured claimant and the health care provider, at the point at which a medical malpractice claim is submitted to a malpractice insurer or a self-insured health care provider.

(b) By agreement of the parties, an expert would be chosen from a pool of health services experts who have agreed to review claims on a voluntary basis.

(c) The mutually agreed upon expert would conduct an impartial review of the claim and provide his or her opinion to the parties.

1 (d) A pool of available experts would be established and maintained
2 for each category of health care practitioner by the corresponding
3 practitioner association, such as the Washington state medical
4 association and the Washington state nurses association.
5 (3) The administrator for the courts shall seek to involve at least
6 the following organizations in a collaborative effort to develop the
7 informal review system described in subsection (2) of this section:
8 (a) The Washington defense trial lawyers association;
9 (b) The Washington state trial lawyers association;
10 (c) The Washington state medical association;
11 (d) The Washington state nurses association;
12 (e) The Washington state hospital association;
13 (f) The Washington state physicians insurance exchange and
14 association;
15 (g) The Washington casualty company;
16 (h) The doctor's agency;
17 (i) Group health cooperative of Puget Sound;
18 (j) The University of Washington;
19 (k) Washington osteopathic medical association;
20 (l) Washington state chiropractic association;
21 (m) Washington association of naturopathic physicians; and
22 (n) The department of health.
23 (4) On or before January 1, 1994, the administrator for the courts
24 shall provide a report on the status of the development of the system
25 described in this section to the governor and the appropriate
26 committees of the senate and the house of representatives.

27 NEW SECTION. **Sec. 420.** A new section is added to chapter 7.70 RCW
28 to read as follows:
29 MANDATORY MEDIATION OF HEALTH CARE MALPRACTICE CLAIMS. (1) All
30 causes of action, whether based in tort, contract, or otherwise, for
31 damages arising from injury occurring as a result of health care
32 provided after the effective date of this section shall be subject to
33 mandatory mediation prior to trial.
34 (2) The supreme court shall by rule adopt procedures to implement
35 mandatory mediation of actions under this chapter. The rules shall
36 address, at a minimum:
37 (a) Procedures for the appointment of, and qualifications of,
38 mediators. A mediator shall have experience or expertise related to

actions arising from injury occurring as a result of health care, and be a member of the state bar association who has been admitted to the bar for a minimum of five years or who is a retired judge. The parties may stipulate to a nonlawyer mediator. The court may prescribe additional qualifications of mediators. Mediators shall be compensated in the same amount and manner as judges pro tempore of the superior court unless the parties agree to a different amount or manner of compensation;

(b) The number of days following the filing of a claim under this chapter within which a mediator must be selected;

(c) The method by which a mediator is selected. The rule shall provide for designation of a mediator by the superior court if the parties are unable to agree upon a mediator;

(d) The number of days following the selection of a mediator within which a mediation conference must be held;

(e) A means by which mediation of an action under this chapter may be waived by a mediator who has determined that the claim is not appropriate for mediation; and

(f) Any other matters deemed necessary by the court.

(3) Mediators shall not impose discovery schedules upon the parties.

NEW SECTION. **Sec. 421.** A new section is added to chapter 7.70 RCW to read as follows:

MANDATORY MEDIATION OF HEALTH CARE MALPRACTICE. The making of a written, good faith request for mediation of a dispute related to damages for injury occurring as a result of health care provided prior to filing a cause of action under this chapter shall toll the statute of limitations provided in RCW 4.16.350.

NEW SECTION. **Sec. 422.** A new section is added to chapter 7.70 RCW to read as follows:

MANDATORY MEDIATION OF HEALTH CARE MALPRACTICE CLAIMS. Section 420 of this act may not be construed to abridge the right to trial by jury following an unsuccessful attempt at mediation.

Sec. 423. RCW 5.60.070 and 1991 c 321 s 1 are each amended to read as follows:

1 (1) If there is a court order to mediate ((~~or~~)), a written
2 agreement between the parties to mediate, or if mediation is mandated
3 under section 420 of this act, then any communication made or materials
4 submitted in, or in connection with, the mediation proceeding, whether
5 made or submitted to or by the mediator, a mediation organization, a
6 party, or any person present, are privileged and confidential and are
7 not subject to disclosure in any judicial or administrative proceeding
8 except:
9 (a) When all parties to the mediation agree, in writing, to
10 disclosure;
11 (b) When the written materials or tangible evidence are otherwise
12 subject to discovery, and were not prepared specifically for use in and
13 actually used in the mediation proceeding;
14 (c) When a written agreement to mediate permits disclosure;
15 (d) When disclosure is mandated by statute;
16 (e) When the written materials consist of a written settlement
17 agreement or other agreement signed by the parties resulting from a
18 mediation proceeding;
19 (f) When those communications or written materials pertain solely
20 to administrative matters incidental to the mediation proceeding,
21 including the agreement to mediate; or
22 (g) In a subsequent action between the mediator and a party to the
23 mediation arising out of the mediation.
24 (2) When there is a court order ((~~or~~)), a written agreement to
25 mediate, or when mediation is mandated under section 420 of this act,
26 as described in subsection (1) of this section, the mediator or a
27 representative of a mediation organization shall not testify in any
28 judicial or administrative proceeding unless:
29 (a) All parties to the mediation and the mediator agree in writing;
30 or
31 (b) In an action described in subsection (1)(g) of this section.

32 **Sec. 424.** RCW 4.22.070 and 1986 c 305 s 401 are each amended to
33 read as follows:
34 (1) Except as provided in subsection (4) of this section, in all
35 actions involving fault of more than one entity, the trier of fact
36 shall determine the percentage of the total fault which is attributable
37 to every entity which caused the claimant's damages, including the
38 claimant or person suffering personal injury or incurring property

1 damage, defendants, third-party defendants, entities released by the
2 claimant, entities immune from liability to the claimant and entities
3 with any other individual defense against the claimant. Judgment shall
4 be entered against each defendant except those who have been released
5 by the claimant or are immune from liability to the claimant or have
6 prevailed on any other individual defense against the claimant in an
7 amount which represents that party's proportionate share of the
8 claimant's total damages. The liability of each defendant shall be
9 several only and shall not be joint except:
10 (a) A party shall be responsible for the fault of another person or
11 for payment of the proportionate share of another party where both were
12 acting in concert or when a person was acting as an agent or servant of
13 the party.
14 (b) If the trier of fact determines that the claimant or party
15 suffering bodily injury or incurring property damages was not at fault,
16 the defendants against whom judgment is entered shall be jointly and
17 severally liable for the sum of their proportionate shares of the
18 claimants total damages.
19 (2) If a defendant is jointly and severally liable under one of the
20 exceptions listed in subsection((~~s~~)) (1)(a) or (1)(b) or (4) (a) or (b)
21 of this section, such defendant's rights to contribution against
22 another jointly and severally liable defendant, and the effect of
23 settlement by either such defendant, shall be determined under RCW
24 4.22.040, 4.22.050, and 4.22.060.
25 (3)(a) Nothing in this section affects any cause of action relating
26 to hazardous wastes or substances or solid waste disposal sites.
27 (b) Nothing in this section shall affect a cause of action arising
28 from the tortious interference with contracts or business relations.
29 (c) Nothing in this section shall affect any cause of action
30 arising from the manufacture or marketing of a fungible product in a
31 generic form which contains no clearly identifiable shape, color, or
32 marking.
33 (4) In all actions governed by chapter 7.70 RCW involving fault of
34 more than one entity, the trier of fact shall determine the percentage
35 of the total fault that is attributable to every entity that caused the
36 claimant's damages, including the claimant or person suffering personal
37 injury or incurring property damage, defendants, third-party
38 defendants, entities released by the claimant, entities immune from
39 liability to the claimant, and entities with any other individual

defense against the claimant. Judgment shall be entered against each defendant except those who have been released by the claimant or are immune from liability to the claimant or have prevailed on any other individual defense against the claimant in an amount that represents that party's proportionate share of the claimant's total damages. The total damages shall first be reduced by any amount paid to the claimant by a released entity. The liability of each defendant shall be several only and shall not be joint except:

(a) A party shall be responsible for the fault of another person or for payment of the proportionate share of another party where both were acting in concert or when a person was acting as an agent or servant of the party.

(b) If the trier of fact determines that the claimant or party suffering bodily injury or incurring property damages was not at fault, the defendants against whom judgment is entered shall be jointly and severally liable for the sum of their proportionate shares of the claimant's total damages.

(c) A defendant shall be responsible to the claimant for any fault of an entity released by the claimant, provided that the total damages shall first be reduced by any amount paid to the claimant by a released entity, and, where some fault has been attributed to the claimant, by the claimant's proportionate share of his or her total damages.

D. HEALTH INSURANCE PURCHASING COOPERATIVES

NEW SECTION. **Sec. 425.** HEALTH INSURANCE PURCHASING COOPERATIVES--DESIGNATION OF REGIONS BY COMMISSION, INFORMATION SYSTEMS, MINIMUM STANDARDS, AND RULES. (1) The health service commission shall designate large geographic regions within the state in which competing health insurance purchasing cooperatives may operate, based upon population, assuming that each cooperative must serve no less than one hundred thousand persons; geographic factors; market conditions; and other factors deemed appropriate by the commission. The commission may designate certain regions of the state as areas where only one cooperative may operate upon a determination that an insufficient population base exists within such region to efficiently support more than one cooperative. The commission shall authorize the creation of ten cooperatives within the state.

1 (2) In coordination with the commission and consistent with the
2 provisions of chapter 70.170 RCW, the department of health shall
3 establish an information clearinghouse for the collection and
4 dissemination of information necessary for the efficient operation of
5 cooperatives, including the establishment of a risk profile information
6 system related to certified health plan enrollees that would permit the
7 equitable distribution of losses among plans in accordance with section
8 406(8) of this act.
9 (3) Every health insurance purchasing cooperative shall:
10 (a) Admit all individuals, employers, or other groups wishing to
11 participate in the cooperative;
12 (b) Make available for purchase by cooperative members every health
13 care program offered by every certified health plan operating within
14 the cooperative's region;
15 (c) Be operated as a member-governed and owned, nonprofit
16 cooperative in which no certified health plan, health maintenance
17 organization, health care service contractor, independent practice
18 association, independent physician organization, or any individual with
19 a pecuniary interest in any such organization, shall have any pecuniary
20 interest in or management control of the cooperative;
21 (d) Provide for centralized enrollment and premium collection and
22 distribution among certified health plans; and
23 (e) Serve as an ombudsman for its members to resolve inquiries,
24 complaints, or other concerns with certified health plans.
25 (4) Every health insurance purchasing cooperative shall assist
26 members in selecting certified health plans and for this purpose may
27 devise a rating system or similar system to judge the quality and cost-
28 effectiveness of certified health plans consistent with guidelines
29 established by the commission. For this purpose, each cooperative and
30 directors, officers, and other employees of the cooperative are immune
31 from liability in any civil action or suit arising from the publication
32 of any report, brochure, or guide, or dissemination of information
33 related to the services, quality, price, or cost-effectiveness of
34 certified plans unless actual malice, fraud, or bad faith is shown.
35 Such immunity is in addition to any common law or statutory privilege
36 or immunity enjoyed by such person, and nothing in this section is
37 intended to abrogate or modify in any way such common law or statutory
38 privilege or immunity.

(5) Every health insurance purchasing cooperative shall bear the full cost of its operations, including the costs of participating in the information clearinghouse, through assessments upon its members. Such assessments shall be billed and accounted for separately from premiums collected and distributed for the purchase of the uniform benefits package or any other supplemental insurance or health services program.

(6) No health insurance purchasing cooperative may bear any financial risk for the delivery of uniform benefits package services, or for any other supplemental insurance or health services program.

(7) No health insurance purchasing cooperative may directly broker, sell, contract for, or provide any insurance or health services program. However, nothing contained in this section shall be deemed to prohibit the use or employment of insurance agents or brokers by the cooperative for other purposes or to prohibit the facilitation of the sale and purchase by members of supplemental insurance or health services programs.

(8) The commission may adopt rules necessary for the implementation of this section including rules governing charter and bylaw provisions of cooperatives and may adopt rules prohibiting or permitting other activities by cooperatives.

(9) The commission shall consider ways in which cooperatives can develop, encourage, and provide incentives for employee wellness programs.

NEW SECTION. **Sec. 426.** LICENSING AND REGULATION OF HEALTH INSURANCE PURCHASING COOPERATIVES BY THE INSURANCE COMMISSIONER. (1) No person may establish or operate a health insurance purchasing cooperative without having first obtained a certificate of authority from the insurance commissioner.

(2) Every proposed cooperative shall furnish notice to the insurance commissioner that shall:

(a) Identify the principal name and address of the cooperative;

(b) Furnish the names and addresses of the initial officers of the cooperative;

(c) Include copies of letters of agreement for participation in the cooperative including minimum term of participation;

(d) Furnish copies of its proposed articles and bylaws; and

(e) Provide other information as prescribed by the insurance commissioner in consultation with the health services commission to verify that the cooperative is qualified and is managed by competent and trustworthy individuals.

(3)(a) The commissioner shall approve applications for certificates in accordance with the order received. Once the maximum number of cooperatives have been issued certificates of authority in each region in accordance with the rules adopted by the health services commission, the insurance commissioner may not issue any new certificate until or unless a previously authorized cooperative surrenders or loses its certificate of authority.

(b) The commissioner shall establish by rule a fee to be paid by cooperatives in an amount necessary to review and approve applications for a certificate of authority. Such fee shall accompany the application and no certificate may be issued until such fee is paid. Fees collected for such purpose shall be deposited in the insurance commissioner's regulatory account in the state treasury.

(4) All funds representing premiums or return premiums received by a cooperative in its fiduciary capacity shall be accounted for and maintained in a separate account from all other funds. Each willful violation of this section constitutes a misdemeanor.

(5) Every cooperative shall keep at its principal address, a record of all transactions it has consummated on behalf of its members with certified health plans. All such records shall be kept available and open to the inspection of the insurance commissioner at any business time during a five-year period immediately after the date of completion of the transaction.

E. CERTIFIED HEALTH PLANS

NEW SECTION. **Sec. 427.** CERTIFIED HEALTH PLANS--REGISTRATION REQUIRED--PENALTY. (1) On or after July 1, 1995, no person or entity in this state shall provide the uniform benefits package and supplemental benefits as defined in section 402 of this act without being certified as a certified health plan by the insurance commissioner.

(2) On or after July 1, 1995, the uniform benefits package and supplemental benefits shall be purchased only from entities certified as certified health plans.

(3) On or after July 1, 1995, the uniform benefits package shall be the minimum benefits package of any certified health plan.

NEW SECTION. **Sec. 428.** HEALTH PLAN CERTIFICATION STANDARDS. A certified health plan shall:

(1) Provide the benefits included in the uniform benefits package and offer supplemental benefits packages to enrolled Washington residents for a prepaid per capita community-rated premium not to exceed the maximum premium established by the commission and provide such benefits through managed care in accordance with rules adopted by the commission;

(2) Accept for enrollment any state resident within the plan's service area and provide or assure the provision of all services within the uniform benefits package and offer supplemental benefits packages regardless of factors referenced in RCW 49.60.020, including age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, or other condition or situation;

(3) If the plan provides benefits through contracts with, ownership of, or management of health care facilities and contracts with or employs health care providers, demonstrate to the satisfaction of the insurance commissioner in consultation with the department of health and the commission that its facilities and personnel are adequate to provide the benefits prescribed in the uniform benefits package and offer supplemental benefits packages to enrolled Washington residents, and that it is financially capable of providing such residents with, or has made adequate contractual arrangements with health care providers and facilities to provide enrollees with such benefits;

(4) Comply with portability of benefits requirements prescribed by the commission;

(5) Comply with administrative rules prescribed by the commission, the insurance commissioner, and other state agencies governing certified health plans;

(6) Provide all enrollees with instruction and informational materials to increase individual and family awareness of injury and illness prevention; encourage assumption of personal responsibility for protecting personal health; and stimulate discussion about the use and limits of medical care in improving the health of individuals and communities;

1 (7) Include in all of its contracts with health care providers and
2 health care facilities a provision prohibiting such providers and
3 facilities from billing enrollees for any amounts in excess of
4 applicable enrollee point of service cost-sharing obligations for
5 services included in the uniform benefits package and the supplemental
6 benefits package;
7 (8) Include in all of its contracts issued for uniform benefits
8 package and supplemental benefits package coverage a subrogation
9 provision that allows the certified health plan to recover the costs of
10 uniform benefits package and supplemental benefits package services
11 incurred to care for an enrollee injured by a negligent third party.
12 The costs recovered shall be limited to:
13 (a) If the certified health plan has not intervened in the action
14 by an injured enrollee against a negligent third party, then the amount
15 of costs the certified health plan can recover shall be limited to the
16 excess remaining after the enrollee has been fully compensated for his
17 or her loss minus a proportionate share of the enrollee's costs and
18 fees in bringing the action. The proportionate share shall be
19 determined by:
20 (i) The fees and costs approved by the court in which the action
21 was initiated; or
22 (ii) The written agreement between the attorney and client that
23 established fees and costs when fees and costs are not addressed by the
24 court.
25 When fees and costs have been approved by a court, after notice to
26 the certified health plan, the certified health plan shall have the
27 right to be heard on the matter of attorneys' fees and costs or its
28 proportionate share;
29 (b) If the certified health plan has intervened in the action by an
30 injured enrollee against a negligent third party, then the amount of
31 costs the certified health plan can recover shall be the excess
32 remaining after the enrollee has been fully compensated for his or her
33 loss or the amount of the plan's incurred costs, whichever is less;
34 (9) Establish and maintain a grievance procedure approved by the
35 commissioner, to provide a reasonable and effective resolution of
36 complaints initiated by enrollees concerning any matter relating to the
37 provision of benefits under the uniform benefits package and
38 supplemental benefits, access to health care services, and quality of
39 services. Each certified health plan shall respond to complaints filed

with the insurance commissioner within fifteen working days. The insurance commissioner in consultation with the commission shall establish standards for grievance procedures and resolution;

(10) Comply with the provisions of chapter 48.30 RCW prohibiting unfair and deceptive acts and practices to the extent such provisions are not modified or superseded by the provisions of chapter . . ., Laws of 1993 (this act) and be prohibited from offering or supplying incentives that would have the effect of avoiding the requirements of subsection (2) of this section;

(11) Have culturally sensitive health promotion programs that include approaches that are specifically effective for persons of color and accommodating to different cultural value systems, gender, and age; and

(12) Permit every class of health care providers to provide health services or care for conditions included in the uniform benefits package and in the supplemental benefits package to the extent that:

(a) The provision of such health services or care is within the health care providers' permitted scope of practice; and

(b) The providers agree to abide by standards related to:

(i) Provision, utilization review, and cost containment of health services;

(ii) Management and administrative procedures; and

(iii) Provision of cost-effective and clinically efficacious health services.

NEW SECTION. **Sec. 429.** LIMITED CERTIFIED HEALTH PLAN FOR DENTAL SERVICES. (1) For the purposes of this section "limited certified dental plan" or "dental plan" means a certified health plan offering coverage for dental services only and that complies with all certified health plan requirements for managed care, community rating, portability, and nondiscrimination.

(2) A dental plan may provide coverage for dental services directly to individuals or to employers for the benefit of employees. If an individual or an employer purchases uniform dental services from a dental plan, the certified health plan covering the individual or the employees need not provide dental services required under the uniform benefits package. A certified health plan may subcontract with a dental plan to provide the dental benefits required under the uniform benefits package.

(3) The commission shall establish maximum premiums and maximum enrollee financial participation amounts that may be charged by dental plans and shall adopt rules defining the minimum, uniform dental services that must be offered by dental plans. The commission shall also establish maximum premiums and maximum enrollee financial participation amounts for certified health plans not providing dental benefits by virtue of the individual's or employee's coverage by a dental plan, and rules governing the percentage change in the premium charged by a dental plan subcontracting with a certified health plan when the maximum premiums are changed by the commission.

(4) Rules governing dental plan premiums and financial participation amounts, and rules defining minimum, uniform dental services shall be adopted and shall apply to dental plans in accordance with the implementation dates applicable to certified health plans with respect to similar requirements.

NEW SECTION. **Sec. 430.** CONTRACTS BETWEEN CERTIFIED HEALTH PLANS AND HEALTH SERVICE PROVIDERS. (1) The legislature finds that not all health service providers, individually or as a class, provide the most cost-effective, efficacious health services for every health need. A fundamental goal of health care reform is to contain the growth in health care costs and related costs in purchasing coverage for health services. In order to achieve this goal, health service providers must either adjust their practice to achieve necessary levels of quality and cost-effectiveness or risk exclusion from certified health plans.

Balancing the need for health care reform and the need to protect health service providers, as a class and as individual providers, from improper exclusion presents a problem that can be satisfied with the creation of a process to ensure fair consideration of the inclusion of health service providers in managed care systems operated by certified health plans. It is therefore the intent of the legislature that the insurance commissioner in developing rules in accordance with this section and the attorney general in monitoring the level of competition in the various geographic markets, balance the need for cost-effective and quality delivery of health services with the need for inclusion of both individual health service providers and classes of health service providers in managed care programs developed by certified health plans. All licensed health service providers, irrespective of the type or kind of practice licensed by the state, should be afforded the opportunity

1 to compete for inclusion in certified health plans consistent with the
2 goals of health care reform.
3 (2) The insurance commissioner shall adopt rules requiring
4 certified health plans to publish general criteria for the plan's
5 selection of health service providers. In adopting such rules, the
6 commissioner shall not require the disclosure of criteria deemed by the
7 plan to be of a proprietary or competitive nature that would hurt the
8 plan's ability to compete or to manage health services. If the
9 commissioner and the plan disagree as to whether criteria is
10 proprietary or its disclosure is anticompetitive, the plan shall be
11 entitled to a hearing and the hearing shall be conducted in a manner
12 that affords the protection of such disputed information from public
13 disclosure. In part, disclosure of criteria is proprietary or
14 anticompetitive if revealing the criteria would have the tendency to
15 cause health service providers to alter their practice pattern in a
16 manner that would harm efforts to contain health care costs and is
17 proprietary if revealing the criteria would cause the plan's
18 competitors to obtain valuable business information.
19 (3) If a certified health plan uses unpublished criteria to judge
20 the quality and cost-effectiveness of a health service provider's
21 practice under any specific program within the plan, the plan may not
22 terminate the provider participating in that program based upon such
23 criteria until the provider has been informed that his or her practice
24 fails to meet such criteria and is given a reasonable opportunity to
25 conform to such criteria.
26 (4) In consultation with the attorney general's office, the
27 insurance commissioner shall adopt rules:
28 (a) Prescribing the terms, conditions, and procedures for binding
29 resolution of contractual disputes between providers and certified
30 health plans to be included in all contracts between providers and
31 plans; and
32 (b) Prescribing the terms, conditions, and procedures for provider
33 appeal to the plan of a decision by the plan not to include the
34 services of the provider.
35 (5) The attorney general with the assistance of the insurance
36 commissioner shall analyze the market power of certified health plans
37 and develop a standard for determining when the market share of any
38 program of a certified health plan reaches a point where the plan's
39 exclusion of health service providers from a program of the plan would

1 result in the substantial inability of providers to continue their
2 practice thereby unreasonably restricting consumer access to needed
3 health services. Whenever, as a result of this analysis, the attorney
4 general determines that a program's share of the market would have the
5 tendency to substantially lessen competition for health services in the
6 relevant market, the certified health plan must allow all providers
7 within the affected market to participate in the program of the
8 certified health plan subject to the following conditions:
9 (a) The provider must meet all published criteria of the program
10 pertaining to the selection of providers;
11 (b) The provider must agree to abide by all published requirements
12 of the program pertaining to utilization review, quality review, and
13 cost containment; and
14 (c) The provider must agree to abide by all administrative and
15 management procedures of the program.
16 Notwithstanding the provisions of this subsection, if the certified
17 health plan demonstrates to the satisfaction of the attorney general
18 that health service utilization data and similar information shows that
19 the inclusion of additional health service providers would
20 substantially lessen the plan's ability to control health care costs
21 and that the plan's procedures for selection of providers are not
22 improperly exclusive of providers, the plan need not include additional
23 providers within the plan's program.
24 (6) Nothing contained in this section shall be construed to require
25 a plan to allow or to continue the participation of a provider:
26 (a) Who violates the terms and conditions of a contract with the
27 plan;
28 (b) Whose provision of health services is inefficient or of poor
29 quality when compared to a provider's peer group which group is
30 objectively determined;
31 (c) Whose health services violate any statute or regulation
32 governing the provider's profession;
33 (d) Whose services are unnecessary because the uniform benefits
34 package does not provide coverage for such services or with respect to
35 a supplemental benefit program, because a supplemental benefit program
36 does not provide coverage for such services; or
37 (e) If the plan is a federally qualified health maintenance
38 organization and the participation of the provider or providers would

prevent the health maintenance organization from operating as a health maintenance organization in accordance with 42 U.S.C Sec. 300e.

NEW SECTION. **Sec. 431.** CERTIFIED HEALTH PLANS--REGISTRATION REQUIRED--PENALTY. (1) No person or entity in this state may, by mail or otherwise, act or hold himself or herself out to be a certified health plan as defined by section 402 of this act without being registered as a certified health plan with the insurance commissioner.

(2) Anyone violating subsection (1) of this section is liable for a fine not to exceed ten thousand dollars and imprisonment not to exceed six months for each instance of such violation.

NEW SECTION. **Sec. 432.** ELIGIBILITY REQUIREMENTS FOR CERTIFICATE OF REGISTRATION--APPLICATION REQUIREMENTS. Any corporation, cooperative group, partnership, association, or groups of health professionals licensed by the state of Washington, public hospital district, or public institutions of higher education are entitled to a certificate from the insurance commissioner as a certified health plan if it:

(1) Submits an application for certification as a certified health plan, which shall be verified by an officer or authorized representative of the applicant, being in a form as the insurance commissioner prescribes in consultation with the health services commission;

(2) Meets the minimum net worth requirements set forth in section 438 of this act and the funding reserve requirements set forth in section 439 of this act;

(3) A certified health plan may establish the geographic boundaries in which they will obligate themselves to deliver the services required under the uniform benefits package and include such information in their application for certification, but the commissioner shall review such boundaries and may disapprove, in conformance to guidelines adopted by the commission, those which have been clearly drawn to be exclusionary within a health care catchment area.

NEW SECTION. **Sec. 433.** ISSUANCE OF CERTIFICATE--GROUNDS FOR REFUSAL. The commissioner shall issue a certificate as a certified health plan to an applicant within one hundred twenty days of such filing unless the commissioner notifies the applicant within such time

that such application is not complete and the reasons therefor; or that the commissioner is not satisfied that:

(1) The basic organization document of the applicant permits the applicant to conduct business as a certified health plan;

(2) The applicant has demonstrated the intent and ability to assure that the health services will be provided in a manner to assure both their availability and accessibility;

(3) The organization is financially responsible and may be reasonably expected to meet its obligations to its enrolled participants. In making this determination, the commissioner shall consider among other relevant factors:

(a) Any agreements with a casualty insurer, a government agency, or any other organization paying or insuring payment for health care services;

(b) Any agreements with providers for the provision of health care services; and

(c) Any arrangements for liability and malpractice insurance coverage.

(4) The procedures for offering health care services are reasonable and equitable; and

(5) Procedures have been established to:

(a) Monitor the quality of care provided by the certified health plan including standards and guidelines provided by the health services commission and other appropriate state agencies;

(b) Operate internal peer review mechanisms; and

(c) Resolve complaints and grievances in accordance with section 443 of this act and rules established by the insurance commissioner in consultation with the commission.

NEW SECTION. **Sec. 434.** PREMIUMS AND ENROLLEE PAYMENT AMOUNTS--FILING OF PREMIUMS AND ENROLLEE PAYMENT AMOUNTS--ADDITIONAL CHARGES PROHIBITED. (1) The insurance commissioner shall verify that the certified health plan and its providers are charging no more than the maximum premiums and enrollee financial participation amounts during the course of financial and market conduct examinations or more frequently if justified in the opinion of the insurance commissioner or upon request by the health services commission.

(2) The certified health plans shall file the premium schedules including employer contributions, enrollee premium sharing, and

1 enrollee point of service cost sharing amounts with the insurance
2 commissioner, within thirty days of establishment by the health
3 services commission.
4 (3) No certified health plan or its provider may charge any fees,
5 assessments, or charges in addition to the premium amount or in excess
6 of the maximum enrollee financial participation limits established by
7 the health services commission. The certified health plan that
8 directly provides health care services may charge and collect the
9 enrollee point of service cost sharing fees as established in the
10 uniform benefits package or other approved benefit plan.

11 NEW SECTION. **Sec. 435.** ANNUAL STATEMENT FILING--CONTENTS--PENALTY
12 FOR FAILURE TO FILE--ACCURACY REQUIRED. (1) Every certified health
13 plan shall annually not later than March 1 of the calendar year, file
14 with the insurance commissioner a statement verified by at least two of
15 its principal officers showing its financial condition as of December
16 31 of the preceding year.
17 (2) Such annual report shall be in such form as the insurance
18 commissioner shall prescribe and shall include:
19 (a) A financial statement of the certified health plan, including
20 its balance sheet and receipts and disbursements for the preceding
21 year, which reflects at a minimum;
22 (i) All prepayments and other payments received for health care
23 services rendered pursuant to certified health plan benefit packages;
24 (ii) Expenditures to all categories of health care facilities,
25 providers, and organizations with which the plan has contracted to
26 fulfill obligations to enrolled residents arising out of the uniform
27 benefits package and other approved supplemental benefit agreements,
28 together with all other direct expenses including depreciation,
29 enrollment, and commission; and
30 (iii) Expenditures for capital improvements, or additions thereto,
31 including but not limited to construction, renovation, or purchase of
32 facilities and capital equipment;
33 (b) A report of the names and addresses of all officers, directors,
34 or trustees of the certified health plan during the preceding year, and
35 the amount of wages, expense reimbursements, or other payments to such
36 individuals. For partnership and professional service corporations, a
37 report shall be made for partners or shareholders as to any
38 compensation or expense reimbursement received by them for services,

1 other than for services and expenses relating directly for patient
2 care;
3 (c) The number of residents enrolled and terminated during the
4 report period. Additional information regarding the enrollment and
5 termination pattern for a certified health plan may be required by the
6 commissioner to demonstrate compliance with the open enrollment and
7 free access requirements of chapter . . ., Laws of 1993 (this act).
8 The insurance commissioner shall specify additional information to be
9 reported, which may include but not be limited to age, sex, location,
10 and health status information;
11 (d) Such other information relating to the performance of the
12 certified health plan or the health care facilities or providers with
13 which it has contracted as reasonably necessary to the proper and
14 effective administration of this chapter in accordance with rules;
15 (e) Disclosure of any financial interests held by officers and
16 directors in any providers associated with the certified health plan or
17 provider of the certified health plan.
18 (3) The commissioner may require quarterly reporting of financial
19 information, such information to be furnished in a format prescribed by
20 the commissioner in consultation with the commission.
21 (4) The commissioner may for good reason allow a reasonable
22 extension of time within which such annual statement shall be filed.
23 (5) The commissioner may suspend or revoke the certificate of a
24 certified health plan for failing to file its annual statement when due
25 or during any extension of time therefor that the commissioner, for
26 good cause, may grant.
27 (6) The commissioner shall publish and make available to the health
28 services commission and the major newspapers of the state an annual
29 summary report of at least the information required in subsections (2)
30 and (3) of this section.
31 (7) No person may knowingly file with any public official or
32 knowingly make, publish, or disseminate any financial statement of a
33 certified health plan that does not accurately state the certified
34 health plan's financial condition.

35 NEW SECTION. **Sec. 436.** PENALTY FOR VIOLATIONS. A certified
36 health plan that, or person who, violates any provision of this chapter
37 is guilty of a gross misdemeanor, unless the penalty is otherwise
38 specifically provided.

1 NEW SECTION. **Sec. 437.** PROVIDER CONTRACTS--ENROLLED RESIDENT'S
2 LIABILITY, COMMISSIONER'S REVIEW. (1) Subject to subsection (2) of
3 this section, every contract between a certified health plan and its
4 providers of health care services shall be in writing and shall set
5 forth that in the event the certified health plan fails to pay for
6 health care services as set forth in the uniform benefits package, the
7 enrollee is not liable to the provider for any sums owed by the
8 certified health plan. Every such contract shall provide that this
9 requirement shall survive termination of the contract.
10 (2) The provisions of subsection (1) of this section shall not
11 apply to emergency care from a provider who is not a contracting
12 provider with the certified health plan, or to emergent and urgently
13 needed out-of-area services.
14 (3) The certified health plan shall file the contracts with the
15 insurance commissioner for approval thirty days prior to use.

16 NEW SECTION. **Sec. 438.** MINIMUM NET WORTH--REQUIREMENTS TO
17 MAINTAIN--DETERMINATION OF AMOUNT. (1) Every certified health plan
18 must maintain a minimum net worth equal to the greater of:
19 (a) One million dollars; or
20 (b) Two percent of annual premium revenues as reported on the most
21 recent annual financial statement filed with the insurance commissioner
22 on the first one hundred fifty million dollars of premium and one
23 percent of annual premium on the premium in excess of one hundred fifty
24 million dollars; or
25 (c) An amount equal to the sum of three months' uncovered
26 expenditures as reported on the most recent financial statement filed
27 with the commissioner.
28 (2)(a) In determining net worth, no debt may be considered fully
29 subordinated unless the subordination clause is in a form acceptable to
30 the commissioner. An interest obligation relating to the repayment of
31 a subordinated debt must be similarly subordinated.
32 (b) The interest expenses relating to the repayment of a fully
33 subordinated debt may not be considered uncovered expenditures.
34 (c) A subordinated debt incurred by a note meeting the requirements
35 of this section, and otherwise acceptable to the insurance
36 commissioner, may not be considered a liability and shall be recorded
37 as equity.

1 (3) Every certified health plan shall, in determining liabilities, 2 include an amount estimated in the aggregate to provide for unearned 3 premiums and for the payment of claims for health care expenditures 4 that have been incurred, whether reported or unreported, that are 5 unpaid and for which such organization is or may be liable and to 6 provide for the expense of adjustment or settlement of such claims.

7 The claims shall be computed in accordance with rules adopted by 8 the insurance commissioner in consultation with the health services 9 commission.

10 NEW SECTION. **Sec. 439.** FUNDED RESERVE REQUIREMENTS. (1) Each 11 certified health plan obtaining certification from the insurance 12 commissioner under sections 427 through 444 of this act shall provide 13 and maintain a funded reserve of one hundred fifty thousand dollars. 14 The funded reserve shall be deposited with the insurance commissioner 15 or with any organization acceptable to the commissioner in the form of 16 cash, securities eligible for investment under chapter 48.13 RCW, 17 approved surety bond, or any combination of these, and must be equal to 18 or exceed one hundred fifty thousand dollars. The funded reserve shall 19 be established as an assurance that the uncovered expenditures 20 obligations of the certified health plan to the enrolled Washington 21 residents shall be performed.

22 (2) All income from reserves on deposit with the commissioner shall 23 belong to the depositing certified health plan and shall be paid to it 24 as it becomes available.

25 (3) Funded reserves required by this section shall be considered an 26 asset in determining the plan's net worth.

27 NEW SECTION. **Sec. 440.** EXAMINATION OF CERTIFIED HEALTH PLANS, 28 POWERS OF COMMISSIONER, DUTIES OF PLANS, INDEPENDENT AUDIT REPORTS. 29 (1) The insurance commissioner shall make an examination of the 30 operations of a certified health plan as often as the commissioner 31 deems it necessary in order to assure the financial security and health 32 and safety of the enrolled residents. The insurance commissioner shall 33 make an examination of a certified health plan not less than once every 34 three calendar years.

35 (2) Every certified health plan shall submit its books and records 36 relating to its operation for financial condition and market conduct 37 examinations and in every way facilitate them. The quality or

1 appropriateness of medical services and systems shall be examined by
2 the department of health except that the insurance commissioner may
3 review such areas to the extent that such items impact the financial
4 condition or the market conduct of the certified health plan. For the
5 purpose of the examinations the insurance commissioner may issue
6 subpoenas, administer oaths, and examine the officers and principals of
7 the certified health plans concerning their business.
8 (3) The insurance commissioner may elect to accept and rely on
9 audit reports made by an independent certified public accountant for
10 the certified health plan in the course of that part of the insurance
11 commissioner's examination covering the same general subject matter as
12 the audit. The commissioner may incorporate the audit report in his or
13 her report of the examination.
14 (4) Certified health plans shall be equitably assessed to cover the
15 cost of financial condition and market conduct examinations, the costs
16 of adopting rules, and the costs of enforcing the provisions of this
17 chapter. The assessments shall be levied not less frequently than
18 once every twelve months and shall be in an amount expected to fund the
19 examinations, adoption of rules, and enforcement of the provisions of
20 this chapter including a reasonable margin for cost variations. The
21 assessments shall be established by rules adopted by the commissioner
22 in consultation with the health services commission but may not exceed
23 five and one-half cents per month per resident enrolled in the
24 certified health plan. The minimum assessment shall be one thousand
25 dollars. Assessment receipts shall be deposited in the insurance
26 commissioner's regulatory account in the state treasury and shall be
27 used for the purpose of funding the examinations authorized in
28 subsection (1) of this section. Assessments received shall be used to
29 pay a pro rata share of the costs, including overhead of regulating
30 certified health plans. Amounts remaining in the separate account at
31 the end of a biennium shall be applied to reduce the assessments in
32 succeeding biennia.

33 <u>NEW SECTION.</u> **Sec. 441.** INSOLVENCY--COMMISSIONER'S DUTIES,
34 CONTINUATION OF BENEFITS, ALLOCATION OF COVERAGE. (1) In the event of
35 insolvency of a certified health plan and upon order of the
36 commissioner, all other certified health plans shall offer the enrolled
37 Washington residents of the insolvent certified health plan the
38 opportunity to enroll in a solvent certified health plan. Enrollment

1 shall be without prejudice for any preexisting condition and shall be
2 continuous provided the resident enrolls in the new certified health
3 plan within thirty days of the date of insolvency and otherwise
4 complies with the certified health plan's managed care procedures
5 within the thirty-day open enrollment period.
6 (2) The insurance commissioner, in consultation with the health
7 services commission, shall establish guidelines for the equitable
8 distribution of the insolvent certified health plan's enrollees to the
9 remaining certified health plans. The guidelines may include
10 limitations to enrollment based on financial conditions, provider
11 delivery network, administrative capabilities of the certified health
12 plan, and other reasonable measures of the certified health plan's
13 ability to provide benefits to the newly enrolled residents.
14 (3) Each certified health plan shall have a plan for handling
15 insolvency that allows for continuation of benefits for the duration of
16 the coverage period for which premiums have been paid and continuation
17 of benefits to enrolled Washington residents who are confined on the
18 date of insolvency in an inpatient facility until their discharge or
19 transfer to a new certified health plan as provided in subsection (1)
20 of this section. The plan shall be approved by the insurance
21 commissioner at the time of certification and shall be submitted for
22 review and approval on an annual basis. The commissioner shall approve
23 such a plan if it includes:
24 (a) Insurance to cover the expenses to be paid for continued
25 benefits after insolvency;
26 (b) Provisions in provider contracts that obligate the provider to
27 provide services for the duration of the period after the certified
28 health plan's insolvency for which premium payment has been made and
29 until the enrolled participant is transferred to a new certified health
30 plan in accordance with subsection (1) of this section. Such extension
31 of coverage shall not obligate the provider of service beyond thirty
32 days following the date of insolvency;
33 (c) Use of the funded reserve requirements as provided under
34 section 439 of this act;
35 (d) Acceptable letters of credit or approved surety bonds; or
36 (e) Other arrangements the insurance commissioner and certified
37 health plan mutually agree are appropriate to assure that benefits are
38 continued.

NEW SECTION. **Sec. 442.** FINANCIAL FAILURE, SUPERVISION OF COMMISSIONER--PRIORITY OF DISTRIBUTION OF ASSETS. (1) Any rehabilitation, liquidation, or conservation of a certified health plan shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the insurance commissioner under the law governing the rehabilitation, liquidation, or conservation of insurance companies. The insurance commissioner may apply for an order directing the insurance commissioner to rehabilitate, liquidate, or conserve a certified health plan upon one or more of the grounds set forth in RCW 48.31.030, 48.31.050, and 48.31.080. Enrolled residents shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) For purposes of determining the priority of distribution of general assets, claims of enrolled residents and their dependents shall have the same priority as established by RCW 48.31.280 for policyholders and their dependents of insurance companies. If an enrolled resident is liable to a provider for services under and covered by a certified health plan, that liability shall have the status of an enrolled resident claim for distribution of general assets.

(3) A provider who is obligated by statute or agreement to hold enrolled residents harmless from liability for services provided under and covered by a certified health plan shall have a priority of distribution of the general assets immediately following that of enrolled residents and enrolled residents' dependents as described in this section, and immediately proceeding the priority of distribution described in RCW 48.31.280(2)(e).

NEW SECTION. **Sec. 443.** GRIEVANCE PROCEDURE. A certified health plan shall establish and maintain a grievance procedure approved by the commissioner, to provide a reasonable and effective resolution of complaints initiated by enrolled Washington residents concerning any matter relating to the provision of benefits under the uniform benefits package, access to health care services, and quality of services. Each certified health plan shall respond to complaints filed with the insurance commissioner within twenty working days. The insurance commissioner in consultation with the health care commission shall establish standards for grievance procedures and resolution.

NEW SECTION. **Sec. 444.** EXEMPTION. The provisions of sections 432 through 443 of this act do not apply to any disability insurance company, health care service contractor, or health maintenance organization authorized to do business in Washington.

NEW SECTION. **Sec. 445.** ENFORCEMENT AUTHORITY OF COMMISSIONER. For the purposes of chapter . . ., Laws of 1993 (this act), the insurance commissioner shall have the same powers and duties of enforcement as are provided in Title 48 RCW.

F. MANAGED COMPETITION AND LIMITED ANTI-TRUST IMMUNITY

NEW SECTION. **Sec. 446.** MANAGED COMPETITION FINDINGS AND INTENT. (1) The legislature recognizes that competition among health care providers, payers, and purchasers will yield the best allocation of health care resources, the lowest prices for health care, and the highest quality of health care when there exists a large number of buyers and sellers, easily comparable health care plans and services, minimal barriers to entry and exit into the health care market, and adequate information for buyers and sellers to base purchasing and production decisions. However, the legislature finds that purchasers of health care services and health care coverage do not have adequate information upon which to base purchasing decisions; that providers of health care services face legal and market disincentives to develop economies of scale or to provide the most cost-efficient and efficacious service; that providers of health care coverage face market disincentives in providing health care coverage to those Washington residents with the most need for health care coverage; and that potential competitors in the provision of health care coverage bear unequal burdens in entering the market for health care coverage.

(2) The legislature therefore intends to displace competition in the health care market to the extent necessary to contain the aggregate cost of health care services; to promote comparability of health care coverage; to improve the cost-effectiveness in providing health care coverage relative to health promotion, disease prevention, and the amelioration or cure of illness; to assure access to a publicly determined, uniform package of health care benefits; and to create reasonable equity in the distribution of funds, treatment, and medical risk among purchasers of health care coverage, payers of health care

services, providers of health care services, and Washington residents. To these ends, any lawful action taken pursuant to chapter . . ., Laws of 1993 (this act) by any person or entity created or regulated by chapter . . ., Laws of 1993 (this act) are declared to be taken pursuant to state statute and in furtherance of the public purposes of the state of Washington.

(3) The legislature does not intend and unless explicitly permitted in accordance with section 447 of this act or under rules adopted pursuant to chapter . . ., Laws of 1993 (this act), does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state and federal anti-trust laws including but not limited to conspiracies to agree or agreements:

(a) Among competing health care providers not to grant discounts, not to provide services, or to fix the terms and conditions of their services;

(b) Among certified health plans as to the price or level of reimbursement for health care services;

(c) Among certified health plans to boycott a group or class of health care service providers;

(d) Among purchasers of certified health plan coverage to boycott a particular plan or class of plans;

(e) Among certified health plans to divide the market for health care coverage; or

(f) Among certified health plans and purchasers to attract or discourage enrollment of any Washington resident or groups of residents in a certified health plan based upon the perceived or actual risk of loss in including such resident or group of residents in a certified health plan or purchasing group.

NEW SECTION. **Sec. 447.** COMPETITIVE OVERSIGHT AND ANTI-TRUST IMMUNITY. (1) A certified health plan, health care facility, health care provider, or other person involved in the development or marketing of health care or certified health plans may request, in writing, that the attorney general issue an informal opinion as to whether particular conduct is authorized by chapter . . ., Laws of 1993 (this act). The attorney general shall issue such opinion within thirty days of receipt of a written request for an opinion or within thirty days of receipt of any additional information requested by the attorney general necessary

1 for rendering an opinion. If the attorney general concludes that such
2 conduct is not authorized by chapter . . ., Laws of 1993 (this act),
3 the person or organization making the request may petition the
4 commission for review and approval of such conduct in accordance with
5 subsection (2) of this section.

6 (2) After consultation with and subject to the approval of the
7 attorney general, the health services commission may authorize conduct
8 requested by petition of a certified health plan, health care facility,
9 health care provider, or any other person that could tend to lessen
10 competition in the relevant market upon a clear and convincing showing
11 that the conduct is necessary to achieve the policy goals of
12 chapter. . ., Laws of 1993 (this act) and a more competitive
13 alternative is unavailable or impractical. Such petition shall be
14 filed in a form and manner prescribed by rule of the commission.

15 After a public hearing, the commission shall issue a written
16 decision approving or denying a petition filed in accordance with this
17 section. The decision shall set forth findings as to benefits and
18 disadvantages and explaining whether the benefits clearly outweigh the
19 disadvantages. Upon the advice of the attorney general, the commission
20 shall consider whether one or more of the following benefits may
21 result:

22 (a) Enhancement of the quality of health services to consumers;

23 (b) Gains in cost-efficiency of health services;

24 (c) Improvements in utilization of health services and equipment;
25 or

26 (d) Avoidance of duplication of health services resources.

27 These benefits must outweigh disadvantages including and not
28 limited to:

29 (i) Reduced competition among certified health plans, health care
30 providers, or health care facilities;

31 (ii) Adverse impact on quality, availability or price of health
32 care services to consumers; or

33 (iii) The availability of arrangements less restrictive to
34 competition that achieve the same benefits.

35 (3) Conduct authorized by the commission shall be deemed taken
36 pursuant to state statute and in the furtherance of the public purposes
37 of the state of Washington.

38 (4) With the assistance of the attorney general's office, the
39 commission shall actively supervise any conduct authorized under this

section and shall periodically review such conduct to determine whether such conduct should be continued and whether a more competitive alterative is available or practical. If the commission determines that the likely benefits of conduct approved by the commission no longer outweigh the disadvantages attributable to potential reduction in competition, the commission shall order a modification or discontinuance of such conduct and such conduct shall no longer be deemed to be taken pursuant to state statute and in the furtherance of the public purposes of the state of Washington.

(5) The commission may adopt all rules necessary to implement this section.

(6) After consultation with and subject to the approval of the attorney general, the commission shall adopt rules:

(a) Governing conduct among providers, health care facilities, and certified health plans including but not limited to the use of "most favored nation" clauses and exclusive dealing clauses in provider contracts;

(b) Permitting health service providers within the service area of a plan to collectively negotiate terms and conditions of contracts with a certified health plan; and

(c) Governing the merger of health care facilities.

G. THE UNIFORM BENEFITS PACKAGE

NEW SECTION. **Sec. 448.** UNIFORM BENEFITS PACKAGE DESIGN. (1) The commission shall define the uniform benefits package, which shall include those health services that, consistent with the goals and intent of chapter . . ., Laws of 1993 (this act), are effective and necessary on a societal basis for the maintenance of the health of citizens of the state, weighed against the need to control state health services expenditures. As the future rate of increase in health services expenditures is controlled, the commission shall consider whether the uniform benefits package should be revised to enhance the services or level of services included in the package.

(2) The schedule of covered health services shall emphasize proven preventive and primary health care and shall include primary and specialty health services, inpatient and outpatient hospital services, prescription drugs and medications, services necessary for maternity and well-child care, including preventive dental services for children,

1 case managed mental health services, short-term skilled nursing
2 facility, home health and hospice services, subject to preapproval, and
3 other services deemed necessary by the commission. The commission
4 shall determine the specific schedule of health services within the
5 uniform benefits package, including limitations on scope and duration
6 of services. The commission shall consider the recommendations of
7 health services effectiveness panels established pursuant to section
8 404 of this act in defining the uniform benefits package.
9 (3) The uniform benefits package shall not limit coverage for
10 preexisting or prior conditions, except that the commission shall
11 establish exclusions for preexisting or prior conditions to the extent
12 necessary to prevent residents from waiting until health services are
13 needed before enrolling in a certified health plan.
14 (4) The commission shall establish a schedule of enrollee point of
15 service cost-sharing for nonpreventive health services, related to
16 enrollee household income, such that financial considerations are not
17 a barrier to access for low-income persons, but that, for those of
18 means, the uniform benefits package provides for moderate point of
19 service cost-sharing. All point of service cost-sharing and cost
20 control requirements shall apply uniformly to all health care providers
21 providing substantially similar uniform benefits package services. The
22 schedule shall provide for an alternate and lower schedule of cost-
23 sharing applicable to enrollees with household income below the federal
24 poverty level.
25 (5) The commission shall adopt rules related to coordination of
26 benefits where a resident has duplicate coverage. The rules shall not
27 have the effect of eliminating enrollee premium sharing or point of
28 service cost-sharing. The commission shall endeavor to assure an
29 equitable distribution, among both employers and employees, of the
30 costs of coverage for those households composed of more than one member
31 in the work force.
32 (6) In determining the uniform benefits package, the commission
33 shall endeavor to seek the opinions of and information from the public.
34 The commission shall consider the results of official public health
35 assessment and policy development activities including recommendations
36 of the department of health in discharging its responsibilities under
37 this section.
38 (7) The commission shall submit the following to the legislature by
39 December 1, 1994, and annually thereafter: (a) The uniform benefits

1 package and any changes it may wish to make; (b) an independent
2 actuarial analysis of the cost of the proposed package; (c) a small
3 business economic impact statement, to be prepared in consultation with
4 the small business advisory committee, describing the economic impact
5 on small business of providing the uniform benefits package to
6 employees and dependents; and (d) if the small business economic impact
7 statement indicates a need for assistance to small businesses,
8 recommended mechanisms to offer such assistance. In developing its
9 recommendations, the commission shall evaluate the potential
10 effectiveness of business and occupation tax credits, a small business
11 assistance fund, and any other mechanism deemed appropriate by the
12 commission.

13 NEW SECTION. **Sec. 449.** SUPPLEMENTAL BENEFIT PACKAGES DESIGN. The
14 commission shall define several supplemental benefits packages, which
15 shall include those health services that, consistent with the goals and
16 intent of chapter . . ., Laws of 1993 (this act), are desirable to
17 expand the available health services defined in the uniform benefits
18 package. Such supplemental benefit packages must be offered only by
19 certified health plans and must be designed in conformance with the
20 procedures and requirements for the design of the uniform benefits
21 package under section 448 of this act. In designing such supplemental
22 benefits packages, the commission shall consider the approach taken by
23 congress and federal agencies in regulating the offering and design of
24 medicare supplemental health insurance policies and the commission
25 shall develop a regulatory method to ensure that pricing of such
26 supplemental benefits packages is consistent with the maximum premium
27 requirements for the uniform benefits package under section 406(6) of
28 this act.

29 NEW SECTION. **Sec. 450.** The legislature may disapprove of the
30 packages developed under sections 448 and 449 of this act by an act of
31 law at any time prior to the thirtieth day of the following regular
32 legislative session. If such disapproval action is taken, the
33 commission shall resubmit modified packages to the legislature within
34 fifteen days of the disapproval. If the legislature does not
35 disapprove the packages or modify them by an act of law by the end of
36 that regular session, they are deemed approved.

NEW SECTION. **Sec. 451.** LONG-TERM CARE INTEGRATION PLAN. (1) To meet the health needs of the residents of Washington state, it is critical to finance and provide long-term care and support services through an integrated, comprehensive system that promotes human dignity and recognizes the individuality of all functionally disabled persons. This system shall be available, accessible, and responsive to all residents based upon an assessment of their functional disabilities. The governor and the legislature recognize that families, volunteers, and community organizations are essential for the delivery of effective and efficient long-term care and support services, and that this private and public service infrastructure should be supported and strengthened. Further, it is important to provide benefits in perpetuity without requiring family or program beneficiary impoverishment for service eligibility.

(2) To realize the need for a strong long-term care system and to carry out the November 30, 1992, final recommendations of the Washington health care commission related to long-term care, the commission shall:

(a) Engage in a planning process, in conjunction with an advisory committee appointed for this purpose, for the inclusion of long-term care services in the uniform benefits package established under section 448 of this act as soon as practicable, but not later than July 1998;

(b) Include in its planning process consideration of the scope of services to be covered, the cost of and financing of such coverage, and the means through which existing long-term care programs and delivery systems can be coordinated and integrated.

(3) The commission shall submit recommendations concerning any necessary statutory changes or modifications of public policy to the governor and the legislature by January 1, 1995.

(4) The departments of health, retirement systems, revenue, social and health services, and veterans' affairs, the offices of financial management, insurance commissioner, and state actuary, along with the health care authority, shall participate in the review of the long-term care needs enumerated in this section and provide necessary supporting documentation and staff expertise as requested by the commission.

(5) The commission shall include in its planning process, the development of two social health maintenance organization long-term care pilot projects. The two pilot projects shall be referred to as the Washington life care pilot projects. Each life care pilot program

1 shall be a single-entry system administered by an individual
2 organization that is responsible for bringing together a full range of
3 medical and long-term care services. The commission, in coordination
4 with the appropriate agencies and departments, shall establish a
5 Washington life care benefits package that shall include the uniform
6 benefits package established in chapter . . ., Laws of 1993 (this act)
7 and long-term care services. The Washington life care benefits package
8 shall include, but not be limited to, the following long-term care
9 services: Case management, intake and assessment, nursing home care,
10 adult family home care, home health and home health aide care, hospice,
11 chore services/homemaker/personal care, adult day care, respite care,
12 and appropriate social services. The pilot project shall develop
13 assessment and case management protocol that emphasize home and
14 community-based care long-term care options.
15 (a) In designing the pilot projects, the commission shall address
16 the following issues: Costs for the long-term care benefits, a
17 projected case-mix based upon disability, the required federal waiver
18 package, reimbursement, capitation methodology, marketing and
19 enrollment, management information systems, identification of the most
20 appropriate case management models, provider contracts, and the
21 preferred organizational design that will serve as a functioning model
22 for efficiently and effectively transitioning long-term care services
23 into the uniform benefits package established in chapter . . ., Laws of
24 1993 (this act). The commission shall also be responsible for
25 establishing the size of the two membership pools.
26 (b) Each program shall enroll applicants based on their level of
27 functional disability and personal care needs. The distribution of
28 these functional level categories and ethnicity within the enrolled
29 program population shall be representative of their distribution within
30 the community, using the best available data to estimate the community
31 distributions.
32 (c) The two sites selected for the Washington life care pilot
33 program shall be drawn from the largest urban areas and include one
34 site in the eastern part of the state and one site in the western part
35 of the state. The two organizations selected to manage and coordinate
36 the life care services shall have the proven ability to provide
37 ambulatory care, personal care/chore services, dental care, case
38 management and referral services, must be accredited and licensed to

1 provide long-term care for home health services, and may be licensed to
2 provide nursing home care.
3 (d) The report on the development and establishment date of the two
4 social health maintenance organizations shall be submitted to the
5 governor and appropriate committees of the legislature by September 16,
6 1994. If the necessary federal waivers cannot be secured by January 1,
7 1995, the commission may elect to not establish the two pilot programs.

8 NEW SECTION. **Sec. 452.** ADDITIONAL BENEFITS. (1) Nothing in
9 chapter . . ., Laws of 1993 (this act) shall preclude insurers, health
10 care service contractors, health maintenance organizations, or
11 certified health plans from insuring, providing, or contracting for
12 additional benefits not included in the uniform benefits package or in
13 supplemental benefits packages designed by the commission.
14 (2) Nothing in chapter . . ., Laws of 1993 (this act) shall
15 restrict the right of an employer to offer, an employee representative
16 to negotiate for, or an individual to purchase additional benefits not
17 included in the uniform benefits package.
18 (3) Nothing in chapter . . ., Laws of 1993 (this act) shall
19 restrict the right of an employer to offer or an employee
20 representative to negotiate for payment of up to one hundred percent of
21 the premium of the lowest priced uniform benefits package available in
22 the geographic area where the employer is located.
23 (4) Pending receipt of necessary federal waivers, nothing in
24 chapter . . ., Laws of 1993 (this act) shall be construed to limit the
25 collective bargaining rights of employee organizations under state or
26 federal law.

27 NEW SECTION. **Sec. 453.** CONSCIENCE OR RELIGION. (1) No certified
28 health plan or health care provider may be required by law or contract
29 in any circumstances to participate in the provision of any uniform
30 benefit if they object to so doing for reason of conscience or
31 religion. No person may be discriminated against in employment or
32 professional privileges because of such objection.
33 (2) The provisions of this section are not intended to result in an
34 enrollee being denied timely access to any service included in the
35 uniform benefits package. Each certified health plan shall:
36 (a) Provide written notice to certified health plan enrollees, upon
37 enrollment with the plan and upon enrollee request thereafter, listing,

by provider, services that any provider refuses to perform for reason of conscience or religion;

(b) Develop written information describing how an enrollee may directly access, in an expeditious manner, services that a provider refuses to perform; and

(c) Ensure that enrollees refused services under this section have prompt access to the information developed pursuant to (b) of this subsection.

H. STATE RESIDENT AND EMPLOYER PARTICIPATION

NEW SECTION. **Sec. 454.** INDIVIDUAL PARTICIPATION. (1) All residents of the state of Washington are required to purchase a uniform benefits package from a certified health plan no later than July 1, 1998. This participation requirement may be waived if imposition of the requirement would constitute a violation of the freedom of religion provisions set forth in the First Amendment, United States Constitution and Article I, section 11 of the state Constitution. Residents of the state of Washington who work in another state for an out-of-state employer shall be deemed to have satisfied the requirements of this section if they receive health insurance coverage through such employer.

(2) The commission shall monitor the enrollment of individuals into certified health plans and shall make public periodic reports concerning the number of persons enrolled and not enrolled, the reasons why individuals are not enrolled, recommendations to reduce the number of persons not enrolled, and recommendations regarding enforcement of this provision.

NEW SECTION. **Sec. 455.** EMPLOYER PARTICIPATION. (1) The legislature recognizes that small businesses play an essential and increasingly important role in the state's economy. The legislature further recognizes that many of the state's small business owners provide health insurance to their employees through small group policies at a cost that directly affects their profitability. Other small business owners are prevented from providing health benefits to their employees by the lack of access to affordable health insurance coverage. The legislature intends that the provisions of chapter . . ., Laws of 1993 (this act) make health insurance more available and

affordable to small businesses in Washington state through strong cost control mechanisms and the option to purchase health benefits through the basic health plan, the Washington state group purchasing association, and health insurance purchasing cooperatives.

(2) In defining the level of mandated employer participation under this section, the commission shall consider the impact of such participation on the financial well-being of the state's employers. In its deliberations, the commission shall evaluate the following:

(a) Whether employers' premium payments should be related to the number of qualified employees the business employs;

(b) Whether different levels of employer premium payments should be applied to employees and dependents;

(c) The profitability of small businesses in Washington state; and

(d) Any other factors deemed necessary by the commission.

(3) On July 1, 1995, every employer employing more than five hundred qualified employees shall offer a choice of the uniform benefits package as provided by at least three available certified health plans, one of which shall be the lowest cost available package within their geographic region, to all qualified employees. The employer shall be required to pay no less than fifty percent and no more than ninety-five percent of the premium cost of the lowest cost available package within their geographic region as determined by the commission. On July 1, 1996, all dependents of qualified employees of these firms shall be offered a choice of packages as provided in this section with the employer paying no less than fifty percent and no more than ninety-five percent of the premium of the lowest cost package within their geographic region as determined by the commission. For part-time employees and their dependents, the employer shall pay the amount resulting from application of the following formula: The number of hours worked by the part-time employee in a month is multiplied by the amount of a qualified employee's premium, and that amount is then divided by eighty.

(4) By July 1, 1996, every employer employing more than one hundred qualified employees shall offer a choice of the uniform benefits package as provided by at least three available certified health plans, one of which shall be the lowest cost available package within their geographic region, to all qualified employees. The employer shall be required to pay no less than fifty percent and no more than ninety-five percent of the premium cost of the lowest cost available package as

determined by the commission. On July 1, 1997, all dependents of qualified employees in these firms shall be offered a choice of packages as provided in this section with the employer paying no less than fifty percent and no more than ninety-five percent of the premium of the lowest cost package within their geographic area as determined by the commission. For part-time employees and their dependents, the employer shall pay the amount resulting from application of the following formula: The number of hours worked by the part-time employee in a month is multiplied by the amount of a qualified employee's premium, and that amount is then divided by eighty.

(5) By July 1, 1997, every employer shall offer a choice of the uniform benefits package as provided by at least three available certified health plans, one of which shall be the lowest cost available package within their geographic region, to all qualified employees. The employer shall be required to pay no less than fifty percent and no more than ninety-five percent of the premium cost of the lowest cost available package as determined by the commission. On July 1, 1998, all dependents of qualified employees in all firms shall be offered a choice of packages as provided in this section with the employer paying no less than fifty percent and no more than ninety-five percent of the premium of the lowest cost package within their geographic area as determined by the commission. For part-time employees and their dependents, the employer shall pay the amount resulting from application of the following formula: The number of hours worked by the part-time employee in a month is multiplied by the amount of a qualified employee's premium, and that amount is then divided by eighty.

(6) This employer participation requirement may be waived if imposition of the requirement would constitute a violation of the freedom of religion provisions of the First Amendment of the United States Constitution and Article I, section 11, of the state Constitution. In such case the employer shall, pursuant to commission rules, set aside an amount equal to the applicable employer contribution level in a manner that would permit his or her employee to fully comply with the requirements of this chapter.

(7) The commission shall adopt rules that address employer participation requirements related to dependents when dependents are eligible for coverage under more than one plan.

(8) In lieu of offering the uniform benefits package to employees and their dependents through direct contracts with certified health plans, an employer may combine the employer contribution with that of the employee's contribution and enroll in the basic health plan as provided in chapter 70.47 RCW or a health insurance purchasing cooperative established under sections 425 and 426 of this act.

(9) The commission shall submit its employer contribution levels and any changes it may wish to make to the legislature by December 1, 1994, and annually thereafter.

NEW SECTION. **Sec. 456.** The legislature may disapprove of the levels under section 455 of this act by an act of law at any time prior to the thirtieth day of the following regular legislative session. If such disapproval action is taken, the commission shall resubmit regular modified employer contribution levels to the legislature within fifteen days of the disapproval. If the legislature does not disapprove the levels or modify them by an act of law by the end of that regular session they shall be deemed approved.

NEW SECTION. **Sec. 457.** Under the guidance and direction of the Washington health services commission not more than two depositories will be established where the premium payments made by employers on behalf of part-time employees may be held in safekeeping for the benefit of such individuals. The commission shall establish, after consultation with representatives of employers and employees, especially those engaged in part-time or seasonal businesses or occupations, appropriate procedures whereby such payments under section 455 of this act will be properly deposited to the credit of such persons on an individual basis, which they in turn may access for the purchase of coverage for themselves and their families from the basic health plan or a certified health plan of their choice.

I. PUBLIC HEALTH SERVICES IMPROVEMENT PLAN

NEW SECTION. **Sec. 458.** A new section is added to chapter 43.70 RCW to read as follows:

PUBLIC HEALTH SERVICES IMPROVEMENT PLAN. (1) The legislature finds that the public health functions of community assessment, policy

1 development, and assurance of service delivery are essential elements
2 in achieving the objectives of health reform in Washington state. The
3 legislature further finds that the population-based services provided
4 by state and local health departments are cost-effective and are a
5 critical strategy for the long-term containment of health care costs.
6 The legislature further finds that the public health system in the
7 state lacks the capacity to fulfill these functions consistent with the
8 needs of a reformed health care system.
9 (2) The department of health shall develop, in consultation with
10 local health departments and districts, the state board of health, the
11 health services commission, area Indian health service, and other state
12 agencies, health services providers, and citizens concerned about
13 public health, a public health services improvement plan. The plan
14 should provide a detailed accounting of deficits in the core functions
15 of assessment, policy development, assurance of the current public
16 health system, how additional public health funding would be used, and
17 describe the benefits expected from expanded expenditures.
18 (3) The plan shall include:
19 (a) Definition of minimum standards for public health protection
20 through assessment, policy development, and assurances;
21 (i) Enumeration of communities not meeting those standards;
22 (ii) A budget and staffing plan for bringing all communities up to
23 minimum standards;
24 (iii) An analysis of the costs and benefits expected from adopting
25 minimum public health standards for assessment, policy development, and
26 assurances;
27 (b) Recommended strategies and a schedule for improving public
28 health programs throughout the state, including:
29 (i) Strategies for transferring personal health care services from
30 the public health system, into the uniform benefits package where
31 feasible; and
32 (ii) Timing of increased funding for public health services linked
33 to specific objectives for improving public health; and
34 (c) A recommended level of dedicated funding for public health
35 services to be expressed in terms of a percentage of total health
36 service expenditures in the state or a set per person amount; such
37 recommendation shall also include methods to ensure that such funding
38 does not supplant existing federal, state, and local funds received by

1 local health departments, and methods of distributing funds among local
2 health departments.
3 (4) By March 1, 1994, the department shall provide initial
4 recommendations of the public health services improvement plan to the
5 legislature regarding minimum public health standards, and public
6 health programs needed to address urgent needs, such as those cited in
7 subsection (6) of this section.
8 (5) By December 1, 1994, the department shall present the public
9 health services improvement plan to the legislature, with specific
10 recommendations for each element of the plan to be implemented over the
11 period from 1995 through 1997.
12 (6) Thereafter, the department shall update the public health
13 services improvement plan for presentation to the legislature prior to
14 the beginning of a new biennium.
15 (7) Among the specific population-based public health activities to
16 be considered in the public health services improvement plan are:
17 Health data assessment and chronic and infectious disease surveillance;
18 rapid response to outbreaks of communicable disease; efforts to prevent
19 and control specific communicable diseases, such as tuberculosis and
20 acquired immune deficiency syndrome; health education to promote
21 healthy behaviors and to reduce the prevalence of chronic disease, such
22 as those linked to the use of tobacco; access to primary care in
23 coordination with existing community and migrant health clinics and
24 other not for profit health care organizations; programs to ensure
25 children are born as healthy as possible and they receive immunizations
26 and adequate nutrition; efforts to prevent intentional and
27 unintentional injury; programs to ensure the safety of drinking water
28 and food supplies; poison control; trauma services; and other
29 activities that have the potential to improve the health of the
30 population or special populations and reduce the need for or cost of
31 health services.

32 **J. HEALTH SERVICES ACCOUNT**

33 NEW SECTION. **Sec. 459.** (1) The health services account is created
34 in the state treasury. All designated receipts from RCW 82.26.020(4),
35 82.24.020(3), 82.08.150(6), 66.24.210(5), 66.24.290(4), 82.04.260(15),
36 and sections 307 through 310 of this act shall be deposited into the
37 account and are subject to appropriation.

(2) The trust fund shall consist of three subsidiary accounts:

(a) The personal health services account from which funds shall be appropriated for the purchase of health services for persons eligible for public subsidies.

(b) The public health account from which funds shall be expended to maintain and improve the health of all Washington residents, through: (i) Assessment and reporting on the population's health status; (ii) development of public policy that promotes and maintains health; and (iii) assuring the availability and delivery of appropriate and effective health interventions. This public system shall be composed of the state board of health, state department of health, and local public health departments and districts. None of the funds shall be used for any service reimbursable through the uniform benefits package.

(c) The health professions, data systems, health systems regulation and research account from which funds shall be expended to:

(i) Retain needed health care providers;

(ii) Conduct research as may be needed on the operation of certified health plans, conduct the operations and activities of the commission, as required by chapter . . ., Laws of 1993 (this act), or to conduct research on public health consistent with the principles set forth in chapter . . ., Laws of 1993 (this act); and

(iii) Finance the development, operation, and maintenance of the health data system according to chapter 70.170 RCW to support the purposes of chapter . . ., Laws of 1993 (this act). Expenditures from the account may be used only for the following purposes:

(3) From the personal health services subsidiary account, operation of the basic health plan, as provided in chapter 70.47 RCW;

(4) From the public health subsidiary account, public health services to maintain and improve the health of Washington residents. For the biennium ending June 30, 1995, public health expenditures from the account shall include but are not limited to:

(a) Measures to increase rates of childhood immunization;

(b) Development and implementation of a counter-message media campaign that has a goal of reducing teen risk behaviors related to tobacco, alcohol and drug use, and sexuality;

(c) Development and implementation of a comprehensive teen pregnancy prevention strategy that includes a media campaign, grants to local communities, and increased access to family planning services;

(d) Reducing the use of tobacco by minors and adults;

(e) Containing and eradicating tuberculosis;
(f) Reducing the incidence of sexually transmitted diseases; and
(g) Slowing the spread of HIV infection.
(5) From the health professions, data systems, health services regulation and research account for the biennium ending June 30, 1995:
(a) Operations of the health services commission established pursuant to section 403 of this act;
(b) Measures to increase the supply and geographic distribution of primary care health services providers, including but not limited to physicians, advanced registered nurse practitioners, and physician assistants, as provided in sections 268, 271, 275, and 276 of this act, and RCW 28B.125.010, 28B.115.080, 70.185.030, 43.70.460, and 43.70.470; and
(c) Development and maintenance of a health services data system, as provided in chapter 70.170 RCW.

K. EXCLUSIONS AND STUDIES

NEW SECTION. **Sec. 460.** CODE REVISIONS AND WAIVERS. (1) The commission shall consider the analysis of state and federal laws that would need to be repealed, amended, or waived to implement chapter . . ., Laws of 1993 (this act), and report its recommendations, with proposed revisions to the Revised Code of Washington, to the governor, and appropriate committees of the legislature by January 1, 1994.
(2) The governor, in consultation with the commission, shall take the following steps in an effort to receive waivers or exemptions from federal statutes necessary to fully implement chapter . . ., Laws of 1993 (this act) to include, but not be limited to:
(a) Negotiate with the United States congress and the federal department of health and human services, health care financing administration to obtain a statutory or regulatory waiver of provisions of the medicaid statute, Title XIX of the federal social security act that currently constitute barriers to full implementation of provisions of chapter . . ., Laws of 1993 (this act) related to access to health services for low-income residents of Washington state. Such waivers shall include any waiver needed to implement managed care programs. Waived provisions may include and are not limited to: Categorical eligibility restrictions related to age, disability, blindness, or family structure; income and resource limitations tied to financial

eligibility requirements of the federal aid to families with dependent children and supplemental security income programs; administrative requirements regarding single state agencies, choice of providers, and fee for service reimbursement programs; and other limitations on health services provider payment methods.

(b) Negotiate with the United States congress and the federal department of health and human services, health care financing administration to obtain a statutory or regulatory waiver of provisions of the medicare statute, Title XVIII of the federal social security act that currently constitute barriers to full implementation of provisions of chapter . . ., Laws of 1993 (this act) related to access to health services for elderly and disabled residents of Washington state. Such waivers shall include any waivers needed to implement managed care programs. Waived provisions include and are not limited to: Beneficiary cost-sharing requirements; restrictions on scope of services; and limitations on health services provider payment methods.

(c) Negotiate with the United States congress and the federal department of health and human services to obtain any statutory or regulatory waivers of provisions of the United States public health services act necessary to ensure integration of federally funded community and migrant health clinics and other health services funded through the public health services act into the health services system established pursuant to chapter . . ., Laws of 1993 (this act). The commission shall request in the waiver that funds from these sources continue to be allocated to federally funded community and migrant health clinics to the extent that such clinics' patients are not yet enrolled in certified health plans.

(d) Negotiate with the United States Congress to obtain a statutory exemption from provisions of the Employee Retirement Income Security Act that limit the state's ability to enact legislation relating to employee health benefits plans administered by employers, including health benefits plans offered by self-insured employers.

(3) On or before December 1, 1995, the commission shall report the following to the governor and appropriate committees of the legislature:

(a) The status of its efforts to obtain the waivers provided in subsection (2) of this section;

(b) The extent to which chapter . . ., Laws of 1993 (this act) can be implemented, given the status of waivers requested or granted; and

(c) If a waiver of the Employee Retirement Income Security Act has not been granted and likely will not be granted in the foreseeable future, changes in chapter . . ., Laws of 1993 (this act) necessary to implement a single-sponsor system, or to implement an alternative system that will assure access to care and control health services costs.

NEW SECTION. **Sec. 461.** REPORTS OF HEALTH CARE COST CONTROL AND ACCESS COMMISSION. In carrying out its powers and duties under chapter . . ., Laws of 1993 (this act), the design of the uniform benefits package, and the development of guidelines and standards, the commission shall consider the reports of the health care cost control and access commission established under House Concurrent Resolution No. 4443 adopted by the legislature in 1990. Nothing in chapter . . ., Laws of 1993 (this act) requires the commission to follow any specific recommendation contained in those reports except as it may also be included in chapter . . ., Laws of 1993 (this act) or other law.

NEW SECTION. **Sec. 462.** EVALUATIONS, PLANS, AND STUDIES. (1) By July 1, 1997, the legislative budget committee either directly or by contract shall conduct the following studies:

(a) A study to determine whether the administrative structure of the Washington health services commission as set forth in section 403 of this act should be continued. The study shall analyze the structure as set forth in chapter . . ., Laws of 1993 (this act), a single administering-agency model, and at least one other salient organizational model, and recommend a structure that would be most efficient and effective;

(b) A study to determine the desirability and feasibility of consolidating the following programs, services, and funding sources into the delivery and financing of uniform benefits package services through certified health plans:

(i) State and federal veterans' health services;

(ii) Civilian health and medical program of the uniformed services (CHAMPUS) of the federal department of defense and other federal agencies; and

(iii) Federal employee health benefits.

(2) The legislative budget committee shall evaluate the implementation of the provisions of chapter . . ., Laws of 1993 (this

act). The study shall determine to what extent chapter . . ., Laws of 1993 (this act) has been implemented consistent with the principles and elements set forth in chapter . . ., Laws of 1993 (this act) and shall report its findings to the governor and appropriate committees of the legislature by July 1, 2003.

NEW SECTION. **Sec. 463.** The commission, the office of financial management, and the legislative evaluation and accountability program committee shall jointly review the financial and accounting structure of all current state-purchased health care programs and any new programs established in chapter . . ., Laws of 1993 (this act). They shall report to the legislature on or before December 1, 1994, with recommendations on how to structure a state-purchased health services budget that: (1) Meets federal and state audit requirements; (2) exercises adequate fiscal and programmatic control; (3) provides management and organizational accountability and control; and (4) provides continuity with historical health services expenditure data.

NEW SECTION. **Sec. 464.** (1) On or before December 1, 1994, the legislative budget committee, whether directly or by contract, shall conduct a study related to coordination of certified health plans and other property and casualty insurance products. The goal of the study shall be to determine methods for containing costs of health services paid for through coverage underwritten by property and casualty insurers.

(2) The study shall address methods to integrate coverage sold by property and casualty insurance companies that covers medical and hospital expenses with coverage provided through certified health plans. In conducting the study, the legislative budget committee shall evaluate at least the following options:

(a) Requiring all property and casualty insurance coverage of health services to be provided through managed care systems rather than through fee for service or indemnification plans;

(b) Prohibiting certified health plans from recovering from property and casualty insurance companies amounts that the plan has expended for health services even if coverage for such services is available under property and casualty insurance policies;

(c) Requiring persons injured as a result of an accident, however caused, to obtain health services through a certified health plan, even

if coverage for health services is available under a property and casualty insurance policy;

(d) Requiring property and casualty insurance companies to reduce premium rates for all coverage duplicated by a certified health plan to the extent that a certified health plan is denied subrogation rights against the property and casualty insurer;

(e) Prohibiting litigation by any person to recover amounts paid for health services available under a certified health plan, except in limited circumstances such as product liability or other areas of negligence where the negligent party would benefit from such a system without contributing to the costs of providing coverage under certified health plans; and

(f) Limiting property and casualty insurance companies' sale of coverage that would duplicate coverage provided by certified health plans.

NEW SECTION. **Sec. 465.** A new section is added to chapter 70.170 RCW to read as follows:

HOSPITAL REGULATION STUDY. The department, through a competitive bidding process restricted to those with suitable expertise to conduct such a study, shall contract for an examination of local, state, and federal regulations that apply to hospitals and shall report to the health care policy committees of the legislature by July 1, 1994, on the following:

(1) An inventory of health and safety regulations that apply to hospitals;

(2) A description of the costs to local, state, and federal agencies for operating the regulatory programs;

(3) An estimate of the costs to hospitals to comply with the regulations;

(4) A description of whether regulatory functions are duplicated among different regulatory programs;

(5) An analysis of the effectiveness of regulatory programs in meeting their safety and health objectives;

(6) An analysis of hospital charity care requirements under RCW 70.170.060 and their relevance under the health care reforms created under chapter . . ., Laws of 1993 (this act);

1 (7) Recommendations on elimination or consolidation of unnecessary
2 or duplicative regulatory activities that would not result in a
3 reduction in the health and safety objectives.

4 NEW SECTION. **Sec. 466.** The department of social and health
5 services aging and adult services administration shall, to the extent
6 that resources are available, review all federal and state laws, and
7 departmental rules that require health care providers in nursing homes
8 to submit documentation. The departmental review shall be conducted to
9 determine what documentation or protocols are redundant and can be
10 modified or eliminated without jeopardizing the health and safety of
11 residents or violating federal regulations. The review shall result in
12 an itemized evaluation of the number of forms requiring physician's
13 review and signature together with a citation of their origin. In
14 addition, the department shall review and suggest efficiencies that
15 could be realized through the development of standardized physicians'
16 protocols for repetitive but nonlifethreatening conditions, such as but
17 not limited to, skin tears, early stage decubiti, bowel and bladder
18 care, and other common and predictable nursing home patient conditions.
19 Whenever possible, source documentation should be enabled to allow
20 multiple attestations to be consolidated into a single document. The
21 department shall conduct this review in coordination with different
22 nursing home care constituent groups and professions, including but not
23 limited to, a gerontologist to be selected by the Washington state
24 medical association and the Washington osteopathic medical association,
25 a nurse to be selected by the Washington state nurses association, one
26 representative from each of the two largest nursing home associations,
27 and a representative of a nursing home residency advocacy group to be
28 selected by the department. The department shall make appropriate
29 regulatory changes, or recommend appropriate regulatory changes to the
30 appropriate regulatory agency, resulting from this review and report
31 its actions and any statutory changes needed to further the goal of
32 regulatory simplification to the chair of the house of representatives
33 health care committee and the chair of the senate health and human
34 services committee by December 12, 1994.

35 NEW SECTION. **Sec. 467.** CERTIFIED HEALTH PLAN COMPETITION. The
36 insurance commissioner shall undertake a study of the feasibility and
37 benefits of developing a single licensing category for certified health

1 plans that would replace current statues licensing disability insurers,
2 health care service contractors, and health maintenance organizations.
3 The commissioner shall report his or her findings and recommendations
4 to the legislature by January 1, 1994. In conducting such study, the
5 commissioner shall:

6 (1) Consider standards for the regulation and inclusion of
7 preferred provider organizations, independent practice associations,
8 and independent physician organizations under such new certified health
9 plan statute;

10 (2) Review existing capital and reserve statutes governing
11 insurers, contractors, and health maintenance organizations to
12 determine the appropriate level of capital and reserve for licensing of
13 certified health plans to protect consumers while encouraging
14 competition in the certified health plan market from new entrants into
15 the market;

16 (3) Review existing rate regulation of disability insurance
17 policies, health care service contracts, and health maintenance
18 agreements and propose a uniform approach for regulation of rates that
19 balances the need of certified health plans to freely compete and the
20 need to protect consumers from inadequate, excessive, or unfairly
21 discriminatory rates;

22 (4) Consider regulatory methods to ensure the adequate provision of
23 and contracting with health care facilities and providers by certified
24 health plans to meet the health care needs of enrollees of certified
25 health plans;

26 (5) Consider the need to modify existing insurance statutes and
27 regulations to govern the integration, development, and marketing of
28 health care coverage that would supplement the uniform benefits
29 package; and

30 (6) Consult with health care service contractors, health
31 maintenance organizations, disability insurance companies, and other
32 health care service providers who would be affected by such changes.

33 NEW SECTION. **Sec. 468.** CRIME VICTIMS' COMPENSATION MEDICAL
34 BENEFITS. (1) On or before January 1, 1995, the department of labor
35 and industries in coordination with the commission, shall complete a
36 study related to the medical services component of the crime victims'
37 compensation program of the department of labor and industries. The
38 goal of the study shall be to determine whether and how the medical

1 services component of the crime victims' compensation program can be
2 modified to provide appropriate medical services to crime victims in a
3 more cost-effective manner. In conducting the study, consideration
4 shall be given to at least the following factors: Required benefit
5 design, necessary statutory changes, and the use of managed care to
6 provide services to crime victims. The study shall evaluate at least
7 the following options:

8 (a) Whether the medical services component of the crime victims'
9 compensation program should be maintained within the department of
10 labor and industries, and its purchasing and other practices modified
11 to control costs and increase efficacy of health services provided to
12 injured workers;

13 (b) Whether the medical services component of the crime victims'
14 compensation program should be administered by the health care
15 authority as the state health care purchasing agent;

16 (c) Whether the medical services component of the crime victims'
17 compensation program should be included in the services offered by
18 certified health plans.

19 (2) The department of labor and industries shall present the
20 recommendations to the governor and the appropriate committees of the
21 legislature by January 1, 1995.

22 **L. WORKERS' COMPENSATION**

23 NEW SECTION. **Sec. 469.** WORKERS' COMPENSATION MEDICAL BENEFITS.
24 (1) An employer who self-insures for employee medical benefits or
25 workers' compensation benefits and who meets the requirements for a
26 certified health plan under section 428 of this act, may apply to the
27 department of labor and industries for an exemption from the
28 requirements of Title 51 RCW regarding the medical portion of the
29 workers' compensation program.

30 (2) The director of the department of labor and industries shall
31 grant such an exemption if he or she finds that (a) the applicant
32 employer has a record of no less than two years of compliance with the
33 requirements to be a certified health plan, (b) the uniform benefit
34 package provided by the certified health plan that would assume
35 workers' compensation responsibilities include medically necessary
36 services available under the workers' compensation program in 1992,
37 including payments for disability determinations, (c) the state has

1 achieved access by no less than ninety-seven percent of all state
2 residents to coverage for the uniform benefit package, (d) there is no
3 reasonable expectation that granting such an exemption will result in
4 a reduction in needed time loss awards or rehabilitative services, (e)
5 the employees' share of workers' compensation medical aid fund
6 contributions are returned to the employee as increased wages, and (f)
7 a majority of employees in the employer's company do not object to the
8 exemption.

9 (3) If, after periodic review of exemptions granted under this
10 section, the director of labor and industries finds that the conditions
11 in subsection (2) of this section are not present, he or she may
12 withdraw the exemption and immediately require the employer to
13 reestablish a separate workers' compensation medical aid fund program.

14 (4) In consultation with representatives of organized labor and the
15 large and small business communities of the state, and consistent with
16 chapter . . ., Laws of 1993 (this act), the statutory workers'
17 compensation advisory committee and the department of labor and
18 industries shall propose a plan and timeline for including the medical
19 services of the workers' compensation program of the department of
20 labor and industries in the services offered by certified health plans.
21 No plan or timeline may take effect until at least ninety-seven percent
22 of state residents have access to the uniform benefit package as
23 required in chapter . . ., Laws of 1993 (this act). No plan or
24 timeline may be proposed that does not assure that (a) the uniform
25 benefit package provides benefits which are medically necessary under
26 the workers' compensation program in 1993, including payment for
27 medical determinations of disability under chapter . . . . . RCW, (b)
28 statutory assurances are provided that time loss benefits and
29 rehabilitative services will not be reduced as a result of the
30 transfer, (c) employers who self-fund for health insurance or workers'
31 compensation and who do not choose to become certified health plans
32 under chapter . . ., Laws of 1993 (this act), will continue to be
33 required to provide workers' compensation benefits as required under
34 1993 law, (d) the employees' share of the workers' compensation medical
35 aid fund contribution is returned to employees as increased wages, and
36 (e) a majority of employees in the employer's company do not object to
37 the change.

1 The medical aid fund portion of the workers' compensation program
2 affected by this section shall not be less than the percentage of the
3 medical aid portion of the workers' compensation program in 1992.
4 To help in developing this plan the department of labor and
5 industries may immediately implement pilot projects to assess the
6 effects of this consolidation on the cost, quality comparability, and
7 employer/employee satisfaction with various consolidation proposals.
8 The plan and timeline required under this subsection shall be
9 presented to the governor and the appropriate committees of the
10 legislature by January 1, 1995. The timeline shall include full
11 implementation of needed rules by July 1, 1998.

12 NEW SECTION. **Sec. 470.** MANAGED CARE PILOT PROJECTS. (1) The
13 department of labor and industries, in consultation with the workers'
14 compensation advisory committee, may implement pilot projects to
15 purchase medical services for injured workers through managed care
16 arrangements. The projects shall assess the effects of managed care on
17 the cost and quality of, and employer and employee satisfaction with,
18 medical services provided to injured workers.
19 (2) The pilot projects may be limited to specific employers. The
20 implementation of a pilot project shall be conditioned upon a
21 participating employer's and a majority of its employees, or the
22 employees' representative, if a collective bargaining agreement exists,
23 voluntarily agreeing to the terms of the pilot. Both the employer and
24 employees are bound by the project agreements for the duration of the
25 project.
26 (3) For participating employers and for the purpose of completing
27 these pilot projects, the projects shall be exempt from the
28 requirements of Title 51 RCW that would prohibit implementation of the
29 pilot projects. Such exemption relates solely to the purpose and
30 duration of the study. Managed care arrangements for the pilot
31 projects may include the designation of doctors responsible for the
32 care delivered to injured workers participating in the projects.
33 (4) The projects shall conclude no later than January 1, 1996. The
34 department shall present the results of the pilot projects and any
35 recommendations related to the projects to the governor and appropriate
36 committees of the legislature on or before October 1, 1996.

37 **M. MISCELLANEOUS**

<u>NEW SECTION.</u> **Sec. 471.** SHORT TITLE. This act may be known and cited as the Washington health services act of 1993.

Sec. 472. RCW 42.17.2401 and 1991 c 200 s 404 are each amended to read as follows:

For the purposes of RCW 42.17.240, the term "executive state officer" includes:

(1) The chief administrative law judge, the director of agriculture, the administrator of the office of marine safety, the administrator of the Washington basic health plan, the director of the department of services for the blind, the director of the state system of community <u>and technical</u> colleges, the director of community development, the secretary of corrections, the director of ecology, the commissioner of employment security, the chairman of the energy facility site evaluation council, the director of the energy office, the secretary of the state finance committee, the director of financial management, the director of fisheries, the executive secretary of the forest practices appeals board, the director of the gambling commission, the director of general administration, the secretary of health, the administrator of the Washington state health care authority, the executive secretary of the health care facilities authority, the executive secretary of the higher education facilities authority, the director of the higher education personnel board, the executive secretary of the horse racing commission, the executive secretary of the human rights commission, the executive secretary of the indeterminate sentence review board, the director of the department of information services, the director of the interagency committee for outdoor recreation, the executive director of the state investment board, the director of labor and industries, the director of licensing, the director of the lottery commission, the director of the office of minority and women's business enterprises, the director of parks and recreation, the director of personnel, the executive director of the public disclosure commission, the director of retirement systems, the director of revenue, the secretary of social and health services, the chief of the Washington state patrol, the executive secretary of the board of tax appeals, the director of trade and economic development, the secretary of transportation, the secretary of the utilities and transportation commission, the director of veterans affairs, the director of wildlife, the president of each of the regional and state

universities and the president of The Evergreen State College, each district and each campus president of each state community college;

(2) Each professional staff member of the office of the governor;

(3) Each professional staff member of the legislature; and

(4) Central Washington University board of trustees, board of trustees of each community college, each member of the state board for community and technical colleges ((~~education~~)), state convention and trade center board of directors, committee for deferred compensation, Eastern Washington University board of trustees, Washington economic development finance authority, The Evergreen State College board of trustees, forest practices appeals board, forest practices board, gambling commission, Washington health care facilities authority, each member of the Washington health services commission, higher education coordinating board, higher education facilities authority, higher education personnel board, horse racing commission, state housing finance commission, human rights commission, indeterminate sentence review board, board of industrial insurance appeals, information services board, interagency committee for outdoor recreation, state investment board, liquor control board, lottery commission, marine oversight board, oil and gas conservation committee, Pacific Northwest electric power and conservation planning council, parks and recreation commission, personnel appeals board, personnel board, board of pilotage ((~~[commissioners]~~)) commissioners, pollution control hearings board, public disclosure commission, public pension commission, shorelines hearing board, ((~~state~~)) public employees' benefits board, board of tax appeals, transportation commission, University of Washington board of regents, utilities and transportation commission, Washington state maritime commission, Washington public power supply system executive board, Washington State University board of regents, Western Washington University board of trustees, and wildlife commission.

Sec. 473. RCW 43.20.050 and 1992 c 34 s 4 are each amended to read as follows:

(1) The state board of health shall provide a forum for the development of public health policy in Washington state. It is authorized to recommend to the secretary means for obtaining appropriate citizen and professional involvement in all public health policy formulation and other matters related to the powers and duties

of the department. It is further empowered to hold hearings and explore ways to improve the health status of the citizenry.

(a) At least every five years, the state board shall convene regional forums to gather citizen input on public health issues.

(b) Every two years, in coordination with the development of the state biennial budget, the state board shall prepare the state public health report that outlines the health priorities of the ensuing biennium. The report shall:

(i) Consider the citizen input gathered at the ((~~health~~)) forums;

(ii) Be developed with the assistance of local health departments;

(iii) Be based on the best available information collected and reviewed according to RCW 43.70.050 and recommendations from the council;

(iv) Be developed with the input of state health care agencies. At least the following directors of state agencies shall provide timely recommendations to the state board on suggested health priorities for the ensuing biennium: The secretary of social and health services, the health care authority administrator, the insurance commissioner, the superintendent of public instruction, the director of labor and industries, the director of ecology, and the director of agriculture;

(v) Be used by state health care agency administrators in preparing proposed agency budgets and executive request legislation;

(vi) Be submitted by the state board to the governor by ((~~June~~)) January 1 of each even-numbered year for adoption by the governor. The governor, no later than ((~~September~~)) March 1 of that year, shall approve, modify, or disapprove the state public health report.

(c) In fulfilling its responsibilities under this subsection, the state board ((~~shall~~)) may create ad hoc committees or other such committees of limited duration as necessary. ((~~Membership should include legislators, providers, consumers, bioethicists, medical economics experts, legal experts, purchasers, and insurers, as necessary.~~))

(2) In order to protect public health, the state board of health shall:

(a) Adopt rules necessary to assure safe and reliable public drinking water and to protect the public health. Such rules shall establish requirements regarding:

1 (i) The design and construction of public water system facilities,
2 including proper sizing of pipes and storage for the number and type of
3 customers;
4 (ii) Drinking water quality standards, monitoring requirements, and
5 laboratory certification requirements;
6 (iii) Public water system management and reporting requirements;
7 (iv) Public water system planning and emergency response
8 requirements;
9 (v) Public water system operation and maintenance requirements;
10 (vi) Water quality, reliability, and management of existing but
11 inadequate public water systems; and
12 (vii) Quality standards for the source or supply, or both source
13 and supply, of water for bottled water plants.
14 (b) Adopt rules and standards for prevention, control, and
15 abatement of health hazards and nuisances related to the disposal of
16 wastes, solid and liquid, including but not limited to sewage, garbage,
17 refuse, and other environmental contaminants; adopt standards and
18 procedures governing the design, construction, and operation of sewage,
19 garbage, refuse and other solid waste collection, treatment, and
20 disposal facilities;
21 (c) Adopt rules controlling public health related to environmental
22 conditions including but not limited to heating, lighting, ventilation,
23 sanitary facilities, cleanliness and space in all types of public
24 facilities including but not limited to food service establishments,
25 schools, institutions, recreational facilities and transient
26 accommodations and in places of work;
27 (d) Adopt rules for the imposition and use of isolation and
28 quarantine;
29 (e) Adopt rules for the prevention and control of infectious and
30 noninfectious diseases, including food and vector borne illness, and
31 rules governing the receipt and conveyance of remains of deceased
32 persons, and such other sanitary matters as admit of and may best be
33 controlled by universal rule; and
34 (f) Adopt rules for accessing existing data bases for the purposes
35 of performing health related research.
36 (3) The state board may delegate any of its rule-adopting authority
37 to the secretary and rescind such delegated authority.
38 (4) All local boards of health, health authorities and officials,
39 officers of state institutions, police officers, sheriffs, constables,

1 and all other officers and employees of the state, or any county, city,
2 or township thereof, shall enforce all rules adopted by the state board
3 of health. In the event of failure or refusal on the part of any
4 member of such boards or any other official or person mentioned in this
5 section to so act, he shall be subject to a fine of not less than fifty
6 dollars, upon first conviction, and not less than one hundred dollars
7 upon second conviction.
8 (5) The state board may advise the secretary on health policy
9 issues pertaining to the department of health and the state.

10 NEW SECTION. **Sec. 474.** RCW 18.32.675 and 1935 c 112 s 19 are each
11 repealed.

12 NEW SECTION. **Sec. 475.** SEVERABILITY. If any provision of this
13 act or its application to any person or circumstance is held invalid,
14 the remainder of the act or the application of the provision to other
15 persons or circumstances is not affected.

16 NEW SECTION. **Sec. 476.** SAVINGS CLAUSE. The enactment of this act
17 does not have the effect of terminating, or in any way modifying, any
18 obligation or any liability, civil or criminal, which was already in
19 existence on the effective date of this act.

20 NEW SECTION. **Sec. 477.** CAPTIONS. Captions used in this act do
21 not constitute any part of the law.

22 NEW SECTION. **Sec. 478.** CODIFICATION. (1) Sections 401 through
23 409, 425, 427 through 429, and 446 through 457 of this act shall
24 constitute a new chapter in Title 43 RCW.
25 (2) Sections 426 and 430 through 445 of this act shall constitute
26 a new chapter in Title 48 RCW.

27 NEW SECTION. **Sec. 479.** RESERVATION OF LEGISLATIVE AUTHORITY. The
28 legislature reserves the right to amend or repeal all or any part of
29 this act at any time and there shall be no vested private right of any
30 kind against such amendment or repeal. All the rights, privileges, or
31 immunities conferred by this act or any acts done pursuant thereto
32 shall exist subject to the power of the legislature to amend or repeal
33 this act at any time.

1 NEW SECTION. **Sec. 480.** EFFECTIVE DATE CLAUSE. (1) This act is
2 necessary for the immediate preservation of the public peace, health,
3 or safety, or support of the state government and its existing public
4 institutions, and shall take effect immediately except for sections 201
5 through 207, 301 through 306, and 311 through 314 of this act which
6 shall take effect July 1, 1993;
7 (2) Sections 307 through 310 of this act shall take effect January
8 1, 1995. Sections 307 through 310 of this act shall be effective in
9 respect to taxes due March 1, 1996, and thereafter; and
10 (3) Sections 231 through 254 of this act shall take effect July 1,
11 1994."

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